



**Learning Together,  
Protecting Tomorrows**

# CDR REPORT FORM

*Version 6.2*

## **National Fatality Review Case Reporting System**

Data Entry Website: [data.ncfrp.org](http://data.ncfrp.org)

Phone: 800-656-2434

Email: [info@ncfrp.org](mailto:info@ncfrp.org)



# Learning Together, Protecting Tomorrows

## Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National Fatality Review Case Reporting System (NFR-CRS). The NFR-CRS is available to states and local sites from the National Center for Fatality Review & Prevention (NCFRP) and requires a data use agreement for data entry. The purpose is to collect comprehensive information from multiple agencies participating in a review. The NFR-CRS documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the team to prevent other deaths.

While this data collection form is an important part of the CDR process, it should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step-by-step manner as part of the team discussion.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available** as a PDF in the Help menu or as individual help icons in the online data entry system. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

The form contains three types of questions: (1) select one response as represented by a circle; (2) select multiple responses as represented by a square; and (3) free text responses. This last type is indicated by the words "specify" or "describe."

Many teams ask what is the difference between leaving a question blank and selecting the response "unknown." A question should be marked "unknown" if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. "N/A" stands for "not applicable" and should be used if the question does not apply.

Throughout the form, a plus sign (+) beside a question indicates that the question is skipped for fetal deaths.

## Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields**, do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital." **Why this reminder?** Text fields may be shared with approved researchers as noted in the Data Use Agreement in your state or jurisdiction. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP. This version includes the SUID (Sudden Unexpected Infant Death) and SDY (Sudden Death in the Young) Case Registry questions.

CASE NUMBER			
_____ / _____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive (fetal/stillborn) <input type="checkbox"/> Child never left hospital following birth	Death Certificate Number: Birth Certificate Number: ME/Coroner Number: Date Team Notified of Death:	
A. CHILD INFORMATION			
A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)		A * symbol means that the question is skipped for fetal deaths.	
1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K			
2. Date of birth: <input type="checkbox"/> U/K _____ / _____ / _____ mm    dd    yyyy	3. Date of death: <input type="checkbox"/> U/K _____ / _____ / _____ mm    dd    yyyy	5. Race, check all that apply: <input type="checkbox"/> Alaska Native, Tribe: _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> U/K	6. Hispanic or Latino/a origin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
4. Age*: <input type="radio"/> Years <input type="radio"/> Hours <input type="radio"/> Months <input type="radio"/> Minutes <input type="radio"/> Days <input type="radio"/> U/K		7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____		9. Child's weight at death*: <input type="checkbox"/> U/K <input type="radio"/> Pounds/ounces _____ / _____ <input type="radio"/> Grams/kilograms _____	11. State of death: _____
13. Child had disability or chronic illness*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical/orthopedic, specify: <input type="checkbox"/> Mental health/substance abuse, specify: <input type="checkbox"/> Cognitive/intellectual, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		10. Child's height at death*: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ / _____ <input type="radio"/> Cm _____	12. County of death: _____
14. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K		15. Child's health insurance, check all that apply*: <input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Indian Health Service <input type="checkbox"/> U/K <input type="checkbox"/> Private <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: _____	
16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule*? <input type="radio"/> NA <input type="radio"/> Yes <input type="radio"/> No, specify: _____ <input type="radio"/> U/K		17. Household income: <input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low <input type="radio"/> U/K	
If the child never left the hospital following birth, go to A2.			
18. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K		19. New residence in past 30 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	20. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 21. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
22. Number of other children living with child: _____ <input type="checkbox"/> U/K		23. Child had history of child maltreatment as victim? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K If yes, how was history identified: <input type="radio"/> Through CPS <input type="radio"/> Other sources If through CPS: _____ # CPS referrals _____ # Substantiations	
24. Was there an open CPS case with child at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		25. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
26. How many months prior to death did child last have contact with a health care provider? _____			
A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD			
27. Child's highest education level: <input type="radio"/> N/A <input type="radio"/> Home schooled, 9-12 <input type="radio"/> None <input type="radio"/> Drop out <input type="radio"/> Preschool <input type="radio"/> HS graduate/GED <input type="radio"/> Grade K-8 <input type="radio"/> College <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8	28. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Not working <input type="radio"/> U/K	29. Did child have problems in school? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Expulsion <input type="checkbox"/> Truancy <input type="checkbox"/> Other, specify: <input type="checkbox"/> Suspensions <input type="checkbox"/> Behavioral <input type="checkbox"/> U/K	30. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K

<p>31. Child had received prior mental health services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Outpatient  <input type="checkbox"/> Day treatment/partial hospitalization  <input type="checkbox"/> Residential</p>	<p>33. Child on medications for mental health illness?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>35. Child was hospitalized for mental health care within the previous 12 months?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, did the child have a follow-up mental health appointment within 30 days of discharge from the hospital?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
<p>32. Child was receiving mental health services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Outpatient <input type="checkbox"/> Residential  <input type="checkbox"/> Day treatment/partial hospitalization</p>	<p>34. Child had emergency department visit for mental health care within the previous 12 months?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, did the child have a follow-up mental health appointment within 30 days of emergency department visit?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>36. Issues prevented child from receiving mental health services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, specify:</p>
<p>37. Child had history of substance use or abuse?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Alcohol <input type="checkbox"/> Prescription drugs, specify:  <input type="checkbox"/> Cocaine <input type="checkbox"/> Over-the-counter drugs, specify:  <input type="checkbox"/> Marijuana <input type="checkbox"/> Tobacco/nicotine, specify type:  <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Opioids <input type="checkbox"/> U/K          If yes, did the child receive treatment?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, type? Check all that apply:  <input type="checkbox"/> Outpatient <input type="checkbox"/> Day treatment/partial hospital  <input type="checkbox"/> Inpatient/detox <input type="checkbox"/> Residential          If yes, age at first use: _____ <input type="checkbox"/> U/K</p>	<p>38. Child had delinquent or criminal history?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Assault <input type="checkbox"/> Weapon  <input type="checkbox"/> Robbery/theft offense  <input type="checkbox"/> Drugs/alcohol <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Misbehavior <input type="checkbox"/> U/K          (truancy, destruction of property, trespassing)</p>	<p>39. Child spent time in juvenile detention?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
<p>40. Child acutely ill in the two weeks before death?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>		

**A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR** A + symbol means that the question is skipped for fetal deaths.

43. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
44. Gestational age: _____ # weeks <input type="checkbox"/> U/K	45. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____	46. Multiple gestation pregnancy? <input type="radio"/> Yes, # of fetuses _____ <input type="radio"/> No <input type="radio"/> U/K	47. Including the deceased infant, how many pregnancies did the mother have? # _____ <input type="checkbox"/> U/K
48. Including the deceased infant, how many live births did the mother have? # _____ <input type="checkbox"/> U/K			
49. Not including the deceased infant, number of children mother still has living? # _____ <input type="checkbox"/> U/K		50. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, number of prenatal visits kept: # _____ <input type="checkbox"/> U/K If yes, what month of pregnancy for first prenatal visit kept. Specify 1-9: _____ <input type="checkbox"/> U/K	

51. Were there access or barrier issues related to prenatal care?  Yes  No  U/K If yes, check all that apply:

<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Couldn't get provider to take as patient	<input type="checkbox"/> Services not available	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Distrust of health care system	
<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Couldn't get an earlier appointment	<input type="checkbox"/> Unwilling to obtain care	<input type="checkbox"/> U/K
<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Didn't know where to go	
<input type="checkbox"/> Language barriers	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> Didn't think she was pregnant	

52. During pregnancy, did the mother have any medical conditions/complications?  Yes  No  U/K If yes, check all that apply:

<p><u>Cardiovascular</u></p> <input type="checkbox"/> Hypertension - gestational <input type="checkbox"/> Hypertension - chronic <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Clotting disorder <p><u>Hematologic</u></p> <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Anemia (iron deficiency) <p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <p><u>Endocrine/Metabolic</u></p> <input type="checkbox"/> Diabetes, type 1 chronic <input type="checkbox"/> Diabetes, type 2 chronic <input type="checkbox"/> Diabetes, gestational <input type="checkbox"/> Thyroid <input type="checkbox"/> Polycystic ovarian disease	<p><u>Neurologic/Psychiatric</u></p> <input type="checkbox"/> Addiction disorder <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Seizure disorder <p><u>Sexually Transmitted Infection (STI)</u></p> <input type="checkbox"/> Bacterial vaginosis (BV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> HPV <input type="checkbox"/> Syphilis <input type="checkbox"/> Group B strep <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other STI, specify:	<p><u>Gynecologic</u></p> <input type="checkbox"/> Uterine/vaginal bleeding <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Intrauterine growth restriction (IUGR) <input type="checkbox"/> Premature rupture of membranes (PROM) <input type="checkbox"/> Preterm premature rupture of membranes (PPROM) <input type="checkbox"/> Cervical Insufficiency <p><u>Umbilical cord complications</u></p> <input type="checkbox"/> Prolapse <input type="checkbox"/> Nuchal cord <input type="checkbox"/> Other cord, specify:	<p><u>Gynecologic (continued)</u></p> <p><u>Placental problems</u></p> <input type="checkbox"/> Abruption <input type="checkbox"/> Previa <input type="checkbox"/> Other placental, specify: <p><u>Other Condition/Complication</u></p> <input type="checkbox"/> UTI <input type="checkbox"/> Decreased fetal movement <input type="checkbox"/> HELLP syndrome <input type="checkbox"/> CBP developmental delay <input type="checkbox"/> Oral health/dental or gum infection <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> CBP genetic disorder <input type="checkbox"/> Abnormal MSAFP <input type="checkbox"/> Preterm labor <input type="checkbox"/> Obesity <input type="checkbox"/> Other, specify:
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<p>53. Did the mother experience any medical complications in previous pregnancies?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Previous small for gestational age  If yes, check all that apply: <input type="checkbox"/> Previous low birth weight birth <input type="checkbox"/> Previous large for gestational age (greater than 4000 grams)</p>																			
<p>54. Did the mother use any medications, drugs or other substances during pregnancy?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:  <input type="checkbox"/> Over-the-counter meds <input type="checkbox"/> Anti-epileptic <input type="checkbox"/> Nausea/vomiting medications <input type="checkbox"/> Cocaine <input type="checkbox"/> Meds to treat drug addiction  <input type="checkbox"/> Allergy medications <input type="checkbox"/> Anti-hypertensives <input type="checkbox"/> Cholesterol medications <input type="checkbox"/> Heroin <input type="checkbox"/> Opioids  <input type="checkbox"/> Antibiotics <input type="checkbox"/> Anti-hypothyroidism <input type="checkbox"/> Meds to treat preterm labor <input type="checkbox"/> Marijuana <input type="checkbox"/> Other pain meds  <input type="checkbox"/> Anti-depressants/ anti-anxiety/ anti-psychotics <input type="checkbox"/> Arthritis medications <input type="checkbox"/> Meds used during delivery <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Diabetes medications <input type="checkbox"/> Progesterone/P17 <input type="checkbox"/> Alcohol <input type="checkbox"/> U/K  <input type="checkbox"/> Asthma medications <input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome?  If any item is checked, please indicate the generic or brand name of the medications or drugs:</p>																			
<p>55. Was the infant/fetus delivered drug exposed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>		<p>56. Did the infant have neonatal abstinence syndrome (NAS)*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																	
<p>57. Level of birth hospital:  <input type="radio"/> 1  <input type="radio"/> 2  <input type="radio"/> 3  <input type="radio"/> 4  <input type="radio"/> Freestanding birth center  <input type="radio"/> Home birth  <input type="radio"/> Other, specify:  <input type="radio"/> U/K</p>	<p>58. At discharge from the birth hospital, was a case manager assigned to the mother?  <input type="radio"/> N/A, mother did not go to a birth hospital <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																		
	<p>59. Did the mother have contact with her care provider within the first 3 weeks postpartum?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																		
	<p>60. Did the infant have a NICU stay of more than one day*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, for what reason(s)? Check all that apply:  <input type="checkbox"/> Prematurity <input type="checkbox"/> Apnea <input type="checkbox"/> Hypothermia <input type="checkbox"/> Meconium aspiration  <input type="checkbox"/> Low birth weight <input type="checkbox"/> Sepsis <input type="checkbox"/> Jaundice <input type="checkbox"/> Congenital anomalies  <input type="checkbox"/> Tachypnea <input type="checkbox"/> Feeding difficulties <input type="checkbox"/> Anemia <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Drug/alcohol exposure <input type="checkbox"/> U/K</p>																		
<p>61. Did the mother smoke in the 3 months before pregnancy?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)  <input type="checkbox"/> U/K quantity</p>	<p>62. Did the mother smoke at any time during pregnancy?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Trimester 1</u></td> <td style="text-align: center;"><u>Trimester 2</u></td> <td style="text-align: center;"><u>Trimester 3</u></td> </tr> <tr> <td>If yes, ___</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td colspan="3" style="text-align: right;">Avg # cigarettes/day (20 cigarettes in pack) U/K quantity</td> </tr> </table>				<u>Trimester 1</u>	<u>Trimester 2</u>	<u>Trimester 3</u>	If yes, ___	___	___	___		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Avg # cigarettes/day (20 cigarettes in pack) U/K quantity		
	<u>Trimester 1</u>	<u>Trimester 2</u>	<u>Trimester 3</u>																
If yes, ___	___	___	___																
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
	Avg # cigarettes/day (20 cigarettes in pack) U/K quantity																		
<p>63. Did the mother use e-cigarettes or other electronic nicotine products at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, on average how often? <input type="radio"/> More than once a day <input type="radio"/> Once a day <input type="radio"/> 2-6 days a week <input type="radio"/> 1 day a week or less <input type="radio"/> U/K</p>																			
<p>64. Was the mother injured during pregnancy?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:</p>		<p>65. Did the mother have postpartum depression?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																	
<p>If this was a fetal death, go to Section B.</p>																			
<p>66. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, any breast milk at 3 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, any breast milk at 6 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If ever, was infant receiving breast milk at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>		<p>67. Did infant have abnormal metabolic newborn screening results?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, describe any abnormality such as a fatty acid oxidation error:</p>																	
<p>If the infant never left the hospital following birth, go to Section B.</p>																			
<p>68. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):  <input type="checkbox"/> None <input type="checkbox"/> Cyanosis  <input type="checkbox"/> Infection <input type="checkbox"/> Seizures or convulsions  <input type="checkbox"/> Allergies <input type="checkbox"/> Cardiac abnormalities  <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Apnea <input type="checkbox"/> U/K</p>		<p>69. In the 72 hours prior to death, did the infant have any of the following?  Check all that apply:  <input type="checkbox"/> None <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Difficulty breathing  <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Apnea  <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Choking <input type="checkbox"/> Cyanosis  <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Diarrhea <input type="checkbox"/> Seizures or convulsions  <input type="checkbox"/> Stool changes <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> U/K</p>																	
<p>70. In the 72 hours prior to death, was the infant injured?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, describe cause and injuries:</p>	<p>71. In the 72 hours prior to death, was the infant given any vaccines?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, list name(s) of vaccines:</p>	<p>72. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies.  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, list name and last dose given:</p>	<p>73. What did the infant have for his/her last meal?  Check all that apply:  <input type="checkbox"/> Breast milk  <input type="checkbox"/> Formula  <input type="checkbox"/> Baby food  <input type="checkbox"/> Cereal  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K</p>																

**B. BIOLOGICAL PARENT INFORMATION**

No information available, go to Section C

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.

Mother alive:  Yes  No  U/K  
Father alive:  Yes  No  U/K

2. Parents' race, check all that apply: <u>Mother</u> <u>Father</u> <input type="checkbox"/> <input type="checkbox"/> Alaska Native, Tribe: <input type="checkbox"/> <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> <input type="checkbox"/> Asian, specify: <input type="checkbox"/> <input type="checkbox"/> Black <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> <input type="checkbox"/> Pacific Islander, specify: <input type="checkbox"/> <input type="checkbox"/> White <input type="checkbox"/> <input type="checkbox"/> U/K		3. Parents' Hispanic or Latino/a origin? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes, specify origin: <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		5. Parents' employment status: <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Employed <input type="radio"/> <input type="radio"/> Unemployed <input type="radio"/> <input type="radio"/> On disability <input type="radio"/> <input type="radio"/> Stay-at-home <input type="radio"/> <input type="radio"/> Retired <input type="radio"/> <input type="radio"/> U/K		6. Parents' education: <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> < High school <input type="radio"/> <input type="radio"/> High school/GED <input type="radio"/> <input type="radio"/> College <input type="radio"/> <input type="radio"/> Post graduate <input type="radio"/> <input type="radio"/> U/K	
4. Parents' age in years at time of child's death: <u>Mother</u> <u>Father</u> _____ # Years <input type="checkbox"/> <input type="checkbox"/> U/K							

7. Parents speak and understand English? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K If no, language spoken:		8. Parents first generation immigrant? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes, country of origin: <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		10. Parents receive social services in the past twelve months? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes   If yes, check all that apply below: <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K			
		9. Parents on active military duty? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes, specify branch: <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		<input type="checkbox"/> <input type="checkbox"/> WIC <input type="checkbox"/> <input type="checkbox"/> Home visiting, specify: <input type="checkbox"/> <input type="checkbox"/> TANF <input type="checkbox"/> <input type="checkbox"/> Medicaid <input type="checkbox"/> <input type="checkbox"/> Food stamps/SNAP/EBT		<input type="checkbox"/> <input type="checkbox"/> Section 8/housing <input type="checkbox"/> <input type="checkbox"/> Social Security Disability Insurance (SSI/SSDI) <input type="checkbox"/> <input type="checkbox"/> Other, specify: <input type="checkbox"/> <input type="checkbox"/> U/K	

11. Parents have substance abuse history? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		12. Parents ever victim of child maltreatment? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		13. Parents ever perpetrator of maltreatment? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		14. Parents have disability or chronic illness? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K	
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15. Parents have prior child deaths? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K		16. Parents have history of intimate partner violence? <u>Mother</u> <u>Father</u> <input type="checkbox"/> <input type="checkbox"/> Yes, as victim <input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> U/K		17. Parents have delinquent/criminal history? <u>Mother</u> <u>Father</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K	
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**C. PRIMARY CAREGIVER(S) INFORMATION**

If fetal death, skip to Section D.

1. Primary caregiver(s): Select only one each in columns one and two.						2. Caregiver(s) age in years: <u>One</u> <u>Two</u> _____ # Years <input type="checkbox"/> <input type="checkbox"/> U/K	
<u>One</u> <u>Two</u> <input type="radio"/> Self, go to Section D <input type="radio"/> <input type="radio"/> Mother, go to Section D <input type="radio"/> <input type="radio"/> Father, go to Section D <input type="radio"/> <input type="radio"/> Adoptive parent <input type="radio"/> <input type="radio"/> Stepparent		<u>One</u> <u>Two</u> <input type="radio"/> <input type="radio"/> Foster parent <input type="radio"/> <input type="radio"/> Parent's partner <input type="radio"/> <input type="radio"/> Grandparent <input type="radio"/> <input type="radio"/> Sibling		<u>One</u> <u>Two</u> <input type="radio"/> <input type="radio"/> Other relative <input type="radio"/> <input type="radio"/> Friend <input type="radio"/> <input type="radio"/> Institutional staff <input type="radio"/> <input type="radio"/> Other, specify: <input type="radio"/> <input type="radio"/> U/K		3. Caregiver(s) sex: <u>One</u> <u>Two</u> <input type="radio"/> <input type="radio"/> Male <input type="radio"/> <input type="radio"/> Female <input type="radio"/> <input type="radio"/> U/K	

4. Caregiver(s) race, check all that apply: <u>One</u> <u>Two</u> <input type="checkbox"/> <input type="checkbox"/> Alaska Native, Tribe: <input type="checkbox"/> <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> <input type="checkbox"/> Asian, specify: <input type="checkbox"/> <input type="checkbox"/> Black <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian				<u>One</u> <u>Two</u> <input type="checkbox"/> <input type="checkbox"/> Pacific Islander, specify: <input type="checkbox"/> <input type="checkbox"/> White <input type="checkbox"/> <input type="checkbox"/> U/K		5. Caregiver(s) Hispanic or Latino/a origin? <u>One</u> <u>Two</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K If yes, specify origin:		6. Caregiver(s) employment status: <u>One</u> <u>Two</u> <input type="radio"/> <input type="radio"/> Employed <input type="radio"/> <input type="radio"/> Unemployed <input type="radio"/> <input type="radio"/> On disability <input type="radio"/> <input type="radio"/> Stay-at-home <input type="radio"/> <input type="radio"/> Retired <input type="radio"/> <input type="radio"/> U/K	
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<p>7. Caregiver(s) education:</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> &lt; High school</p> <p><input type="radio"/> <input type="radio"/> High school/GED</p> <p><input type="radio"/> <input type="radio"/> College</p> <p><input type="radio"/> <input type="radio"/> Post graduate</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>8. Do caregiver(s) speak and understand English?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>9. Caregiver(s) first generation immigrant?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes, country of origin:</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>10. Caregiver(s) on active military duty?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes, specify branch:</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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<p>11. Caregiver(s) receive social services in the past twelve months?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes If yes, check all services that apply:</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>						<p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> WIC</p> <p><input type="checkbox"/> <input type="checkbox"/> Home visiting</p> <p>specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> TANF</p> <p><input type="checkbox"/> <input type="checkbox"/> Medicaid</p>		<p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Food stamps/SNAP/EBT</p> <p><input type="checkbox"/> <input type="checkbox"/> Section 8/housing</p> <p><input type="checkbox"/> <input type="checkbox"/> Soc Sec Disability (SSI/SSDI)</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	
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<p>12. Caregiver(s) have substance abuse history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>13. Caregiver(s) ever victim of child maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>14. Caregiver(s) ever perpetrator of maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>15. Caregiver(s) have disability or chronic illness?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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<p>16. Caregiver(s) have prior child deaths?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>17. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>18. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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**D. SUPERVISOR INFORMATION** Answer this section only if the child ever left the hospital following birth

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> Yes, answer D2-16</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sec. E</p> <p><input type="radio"/> No, but needed, answer D3-16</p> <p><input type="radio"/> Unable to determine, try to answer D3-16</p>	<p>2. How long before incident did supervisor last see child?</p> <p>Select one:</p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____ <input type="radio"/> Days _____</p> <p><input type="radio"/> Hours _____ <input type="radio"/> U/K</p>
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<p>3. Is supervisor listed in a previous section?</p> <p><input type="radio"/> Yes, mother, go to D15</p> <p><input type="radio"/> Yes, father, go to D15</p> <p><input type="radio"/> Yes, caregiver one, go to D15</p> <p><input type="radio"/> Yes, caregiver two, go to D15</p> <p><input type="radio"/> No</p>	<p>4. Primary person responsible for supervision at the time of incident? Select only one:</p> <p><input type="radio"/> Adoptive parent <input type="radio"/> Sibling <input type="radio"/> Institutional staff, go to D15</p> <p><input type="radio"/> Stepparent <input type="radio"/> Other relative <input type="radio"/> Babysitter</p> <p><input type="radio"/> Foster parent <input type="radio"/> Friend <input type="radio"/> Licensed child care worker</p> <p><input type="radio"/> Parent's partner <input type="radio"/> Acquaintance <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Grandparent <input type="radio"/> Hospital staff, go to D15 <input type="radio"/> U/K</p>
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<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</p>	<p>7. Supervisor speaks and understands English?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
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<p>9. Supervisor has substance abuse history?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
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<p>13. Supervisor has history of intimate partner violence?</p> <p><input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> U/K</p>	<p>14. Supervisor has delinquent or criminal history?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>15. At the time of the incident, was the supervisor asleep? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, select the most appropriate description of the supervisor's sleeping period at incident:</p> <p><input type="radio"/> Night time sleep</p> <p><input type="radio"/> Day time nap, describe:</p> <p><input type="radio"/> Day time sleep (for example, supervisor is night shift worker), describe:</p> <p><input type="radio"/> Other, describe:</p>	<p>16. At time of incident was supervisor impaired? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Drug impaired, specify:</p> <p><input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> Absent</p> <p><input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> Other, specify:</p>
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**E. INCIDENT INFORMATION**

Answer only E7 if the child never left the hospital following birth

<p>1. Was the date of the incident the same as the date of death?  <input type="radio"/> Yes, same as date of death  <input type="radio"/> No, different than date of death. Enter date of incident:    ___/___/___  <input type="radio"/> U/K  <div style="text-align: right; margin-left: 200px;">mm / dd / yyyy</div></p>	<p>2. Approximate time of day that incident occurred?  <input type="radio"/> AM  Hour, specify 1-12: _____ <input type="radio"/> PM  <input type="radio"/> U/K</p>																								
<p>3. Place of incident, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Child's home</td> <td><input type="checkbox"/> Licensed child care center</td> <td><input type="checkbox"/> Military installation</td> <td><input type="checkbox"/> State or county park, other recreation area</td> </tr> <tr> <td><input type="checkbox"/> Relative's home</td> <td><input type="checkbox"/> Licensed child care home</td> <td><input type="checkbox"/> Jail/detention facility</td> <td><input type="checkbox"/> Hospital</td> </tr> <tr> <td><input type="checkbox"/> Friend's home</td> <td><input type="checkbox"/> Unlicensed child care home</td> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Licensed foster care home</td> <td><input type="checkbox"/> Farm/ranch</td> <td><input type="checkbox"/> Roadway</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Relative foster care home</td> <td><input type="checkbox"/> School</td> <td><input type="checkbox"/> Driveway</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Licensed group home</td> <td><input type="checkbox"/> Indian reservation/trust lands</td> <td><input type="checkbox"/> Other parking area</td> <td></td> </tr> </table>		<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Military installation	<input type="checkbox"/> State or county park, other recreation area	<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Jail/detention facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Friend's home	<input type="checkbox"/> Unlicensed child care home	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Licensed foster care home	<input type="checkbox"/> Farm/ranch	<input type="checkbox"/> Roadway	<input type="checkbox"/> U/K	<input type="checkbox"/> Relative foster care home	<input type="checkbox"/> School	<input type="checkbox"/> Driveway		<input type="checkbox"/> Licensed group home	<input type="checkbox"/> Indian reservation/trust lands	<input type="checkbox"/> Other parking area	
<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Military installation	<input type="checkbox"/> State or county park, other recreation area																						
<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Jail/detention facility	<input type="checkbox"/> Hospital																						
<input type="checkbox"/> Friend's home	<input type="checkbox"/> Unlicensed child care home	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Other, specify: _____																						
<input type="checkbox"/> Licensed foster care home	<input type="checkbox"/> Farm/ranch	<input type="checkbox"/> Roadway	<input type="checkbox"/> U/K																						
<input type="checkbox"/> Relative foster care home	<input type="checkbox"/> School	<input type="checkbox"/> Driveway																							
<input type="checkbox"/> Licensed group home	<input type="checkbox"/> Indian reservation/trust lands	<input type="checkbox"/> Other parking area																							
<p>4. Type of area:    <input type="radio"/> Urban   <input type="radio"/> Suburban   <input type="radio"/> Rural   <input type="radio"/> Frontier   <input type="radio"/> U/K</p>																									
<p>5. Incident state: _____</p>	<p>6. Incident county: _____</p>																								
<p>7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:  If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, etc.):</p>																									
<p>8. Was the incident witnessed?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, by whom?</p>	<p><input type="checkbox"/> Parent/relative  <input type="checkbox"/> Other caretaker/babysitter  <input type="checkbox"/> Teacher/coach/athletic trainer  <input type="checkbox"/> Other acquaintance</p> <p><input type="checkbox"/> Health care professional, if death occurred in a hospital setting  <input type="checkbox"/> Stranger  <input type="checkbox"/> Other, specify: _____</p>																								
<p>9. Was 911 or local emergency called?  <input type="radio"/> N/A   <input type="radio"/> Yes  <input type="radio"/> No   <input type="radio"/> U/K</p>																									
<p>10. Was resuscitation attempted?  <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, by whom?</p>	<p>If yes, type of resuscitation:  <input type="checkbox"/> CPR  <input type="checkbox"/> Automated External Defibrillator (AED)  If no AED, was AED available/accessible?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If AED, was shock administered?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, how many shocks were administered? _____  <input type="checkbox"/> Rescue medications, including naloxone, specify type:  <input type="checkbox"/> Other, specify: _____</p>	<p>If yes, was a rhythm recorded?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, what was the rhythm?  _____</p>																							
<p>11. At time of incident leading to death, had child used drugs or alcohol?  <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> Opioids</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Cocaine</td> <td><input type="checkbox"/> Prescription drugs</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Marijuana</td> <td><input type="checkbox"/> Over-the-counter drugs</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Methamphetamine</td> <td><input type="checkbox"/> Other, specify: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Opioids	<input type="checkbox"/> U/K	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Prescription drugs		<input type="checkbox"/> Marijuana	<input type="checkbox"/> Over-the-counter drugs		<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other, specify: _____		<p>12. Child's activity at time of incident, check all that apply:  <input type="checkbox"/> Sleeping   <input type="checkbox"/> Working   <input type="checkbox"/> Driving/vehicle occupant   <input type="checkbox"/> U/K  <input type="checkbox"/> Playing   <input type="checkbox"/> Eating   <input type="checkbox"/> Other, specify: _____</p> <p>13. Total number of deaths at incident event, including child:  _____ Children, ages 0-18  _____ Adults  <input type="checkbox"/> U/K</p>												
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Opioids	<input type="checkbox"/> U/K																							
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Prescription drugs																								
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Over-the-counter drugs																								
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other, specify: _____																								

**F. INVESTIGATION INFORMATION**

A + symbol means that the question is skipped for fetal deaths.

<p>1. Was a death investigation conducted*? <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  <input type="checkbox"/> Medical examiner   <input type="checkbox"/> ME investigator   <input type="checkbox"/> Law enforcement   <input type="checkbox"/> EMS   <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Coroner   <input type="checkbox"/> Coroner investigator   <input type="checkbox"/> Fire investigator   <input type="checkbox"/> Child Protective Services   <input type="checkbox"/> U/K</p> <p>If yes, which of the following death investigation components were completed?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u></td> <td style="text-align: center;"><u>No</u></td> <td style="text-align: center;"><u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Narrative description of circumstances</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene photos</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene recreation with doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene recreation without doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Witness interviews</td> </tr> </table> <p>If yes, was a death scene investigation conducted at the place of incident?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<u>Yes</u>	<u>No</u>	<u>U/K</u>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<p>If yes, check all that apply:  <input type="checkbox"/> Yes   <input type="checkbox"/> No  If yes, shared with review team?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>No</td> </tr> </table>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No
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<p>2. What additional information would the team like to have known about the death scene investigation*?</p>																																																																	

<p>3. Death referred to*:  <input type="radio"/> Medical examiner    <input type="radio"/> Not referred  <input type="radio"/> Coroner    <input type="radio"/> U/K</p>	<p>4. Person declaring official cause and manner of death*:  <input type="radio"/> Medical examiner    <input type="radio"/> Hospital physician    <input type="radio"/> Mortician    <input type="radio"/> U/K  <input type="radio"/> Coroner    <input type="radio"/> Other physician    <input type="radio"/> Other, specify:</p>
<p>5. Autopsy performed?    <input type="radio"/> Yes <input type="radio"/> No    <input type="radio"/> U/K  If yes, conducted by: <input type="radio"/> Forensic pathologist    <input type="radio"/> Unknown type pathologist    If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?  <input type="radio"/> Pediatric pathologist    <input type="radio"/> Other physician    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, specify specialist: _____  <input type="radio"/> General pathologist    <input type="radio"/> Other, specify: _____  <input type="radio"/> U/K    If no, why not (e.g. parent or caregiver objected)? _____</p>	
<p>6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10.  Yes    No    U/K  <b>Imaging:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - single  <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - multiple views  <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - complete skeletal series  <input type="radio"/> <input type="radio"/> <input type="radio"/> Other imaging, specify (includes MRI, CT scan, photos of the brain, etc): _____</p>	<p>7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10.  Yes    No    U/K  <input type="radio"/> <input type="radio"/> <input type="radio"/> Cultures for infectious disease  <input type="radio"/> <input type="radio"/> <input type="radio"/> Microscopic/histologic exam  <input type="radio"/> <input type="radio"/> <input type="radio"/> Postmortem metabolic screen  <input type="radio"/> <input type="radio"/> <input type="radio"/> Vitreous testing  <input type="radio"/> <input type="radio"/> <input type="radio"/> Genetic testing</p>
<p>8. Was any toxicology testing performed on the child?    <input type="radio"/> Yes <input type="radio"/> No    <input type="radio"/> U/K  If yes, what were the results? <input type="checkbox"/> Negative    <input type="checkbox"/> Cocaine    <input type="checkbox"/> Methamphetamine    <input type="checkbox"/> Too high Rx drug, specify: _____    <input type="checkbox"/> Other, specify: _____  Check all that apply:    <input type="checkbox"/> Alcohol    <input type="checkbox"/> Marijuana    <input type="checkbox"/> Opioids    <input type="checkbox"/> Too high OTC drug, specify: _____    <input type="checkbox"/> U/K</p>	
<p>9. Was the child's medical history reviewed as part of the autopsy*?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K  If yes, did this include:    Review of the newborn metabolic screen results?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    <input type="radio"/> Not performed  Review of neonatal CCHD screen results?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    <input type="radio"/> Not performed</p>	
<p>10. Describe any abnormalities or other significant findings noted in the autopsy*:</p>	
<p>11. What additional information would the team like to have known about the autopsy*?</p>	<p>12. Was there agreement between the cause of death listed on the autopsy report and on the death certificate*?    <input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K  If no, describe the differences: _____</p>
<p>13. Was a CPS record check conducted as a result of death*?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	
<p>14. Did the child ever have any injuries that were suspicious of child abuse*?  <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, what injuries were found?  <input type="checkbox"/> Skin injury    <input type="checkbox"/> Broken bones    <input type="checkbox"/> Abdominal injury  <input type="checkbox"/> Mouth injury    <input type="checkbox"/> Head injury    <input type="checkbox"/> U/K  <input type="checkbox"/> Burns</p>	<p>15. Did any investigation find evidence of prior abuse*?  <input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, from what source?  <input type="checkbox"/> From x-rays    <input type="checkbox"/> From law enforcement  <input type="checkbox"/> From autopsy    <input type="checkbox"/> U/K  <input type="checkbox"/> From CPS review</p>
<p>16. CPS action taken because of death*?    <input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K  If yes, highest level of action taken because of death:  <input type="radio"/> Report screened out and not investigated  <input type="radio"/> Unsubstantiated  <input type="radio"/> Inconclusive  <input type="radio"/> Substantiated</p>	<p>If yes, what services or actions resulted? Check all that apply:  <input type="checkbox"/> Voluntary services offered    <input type="checkbox"/> Court-ordered out of home placement  <input type="checkbox"/> Voluntary services provided    <input type="checkbox"/> Children removed  <input type="checkbox"/> Court-ordered services provided    <input type="checkbox"/> Parental rights terminated  <input type="checkbox"/> Voluntary out of home placement    <input type="checkbox"/> U/K</p>
<p>17. If death occurred in licensed setting (see E3), indicate action taken*:  <input type="radio"/> No action  <input type="radio"/> License suspended  <input type="radio"/> License revoked  <input type="radio"/> Investigation ongoing  <input type="radio"/> Other, specify: _____  <input type="radio"/> U/K</p>	
<p><b>G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH</b></p>	
<p>1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: _____    <input type="checkbox"/> U/K</p>	
<p>2. Enter the following information exactly as written on the death certificate:    <input type="checkbox"/> U/K  Immediate cause (final disease or condition resulting in death):  a.  Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:  b.  c.  d.</p>	
<p>3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate:    <input type="checkbox"/> U/K</p>	
<p>4. If injury, describe how injury occurred exactly as written on the death certificate: _____    <input type="checkbox"/> U/K</p>	

5. Official manner of death from the death certificate:

Natural

Accident

Suicide

Homicide

Undetermined

Pending

U/K

If manner of death was not Natural or Suicide, check this box if it is possible that the child intended to hurt him/herself. If checked, complete the Suicide Section (I6) to note other risk factors in the child's life.

6. Primary cause of death: Choose 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

From an external cause of injury. Select one:

Motor vehicle and other transport, go to H1

Fire, burn, or electrocution, go to H2

Drowning, go to H3

Asphyxia, go to H4

Bodily force or weapon, go to H5

Fall or crush, go to H6

Poisoning, overdose or acute intoxication, go to H7

Undetermined injury, go to I1

Other cause, go to H9

U/K, go to I1

From a medical cause. Select one and go to H8:

Asthma/respiratory, specify:

Cancer, specify:

Cardiovascular, specify:

Congenital anomaly, specify:

COVID-19

Diabetes

HIV/AIDS

Influenza

Low birth weight

Malnutrition/dehydration

Neurological/seizure disorder

Pneumonia, specify:

Prematurity

SIDS

Other infection, specify:

Other perinatal condition, specify:

Other medical condition, specify:

Undetermined medical cause

U/K

Undetermined if injury or medical cause, go to I1

U/K, go to I1

**H. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE THE ONE SECTION THAT IS SAME AS THE CAUSE SELECTED ABOVE**

**H1. MOTOR VEHICLE AND OTHER TRANSPORT**

a. Vehicles involved in incident:

Total number of vehicles: \_\_\_\_\_

Child's	Other primary vehicle	
<input type="radio"/>	<input type="radio"/>	None
<input type="radio"/>	<input type="radio"/>	Car
<input type="radio"/>	<input type="radio"/>	Van
<input type="radio"/>	<input type="radio"/>	Sport utility vehicle
<input type="radio"/>	<input type="radio"/>	Truck
<input type="radio"/>	<input type="radio"/>	Semi/tractor trailer
<input type="radio"/>	<input type="radio"/>	RV/bus/school bus
<input type="radio"/>	<input type="radio"/>	Motorcycle
<input type="radio"/>	<input type="radio"/>	Tractor/farm vehicle
<input type="radio"/>	<input type="radio"/>	All terrain vehicle
<input type="radio"/>	<input type="radio"/>	Snowmobile
<input type="radio"/>	<input type="radio"/>	Bicycle
<input type="radio"/>	<input type="radio"/>	Train/subway/trolley
<input type="radio"/>	<input type="radio"/>	Other, specify:
<input type="radio"/>	<input type="radio"/>	U/K

Autonomous?

	N/A	Yes	No	U/K
Child's vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

b. Position of child:

Driver

Passenger

Front seat

Back seat

Truck bed

Other, specify:

U/K

On bicycle

Pedestrian

Walking

Boarding/blading

Other, specify:

U/K

U/K

If passenger, relationship of driver to child:

Biological parent

Adoptive parent

Stepparent

Foster parent

Parent's partner

Grandparent

Sibling

Other relative

Friend

Other, specify:

U/K

If bicycle, boarding/blading or other, was the child riding something electric?

Yes  No  U/K

c. Did any of the following contribute to the incident? Check all that apply:

<input type="checkbox"/> None listed below	<input type="checkbox"/> Poor sight line
<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Road hazard
<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Car changing lanes
<input type="checkbox"/> Recklessness	<input type="checkbox"/> Driver inexperience
<input type="checkbox"/> Carelessness	<input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation
<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Driver distraction
<input type="checkbox"/> Drug use	<input type="checkbox"/> Ran stop sign or red light
<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Other driver error, specify:
<input type="checkbox"/> Vehicle ran over child	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Vehicle flipped over	<input type="checkbox"/> U/K
<input type="checkbox"/> Poor weather	
<input type="checkbox"/> Poor visibility	

d. Location of incident, check all that apply:

City street

Residential street

Rural road

Highway

Intersection

Driveway

Parking area

Off road

RR xing/tracks

Other, specify:

U/K

e. Did driving conditions factor into this incident?

Yes  No  U/K

If yes, check all that apply:

Loose gravel

Ice/snow

Wet

Inadequate lighting

Other, specify:

U/K

<p>f. Incident type:</p> <p><input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle</p> <p><input type="radio"/> Child in/on a vehicle, struck by the other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck the other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck person/object/ran off the road</p> <p><input type="radio"/> Other event, specify:</p> <p><input type="radio"/> U/K</p>		<p>g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.</p> <p><input type="radio"/> Child was responsible as driver of vehicle, including single vehicle incidents</p> <p><input type="radio"/> Driver of child's vehicle was responsible, including single vehicle incidents</p> <p><input type="radio"/> Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle</p> <p><input type="radio"/> Multiple drivers were responsible, go to j</p> <p><input type="radio"/> Unable to determine driver responsible, go to j</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	
<p>h. Age and license type of driver responsible for incident, check all that apply:</p> <p>Age of Driver (if not child) License type/violation:</p> <p><input type="radio"/> &lt;16 years <input type="checkbox"/> Has no license</p> <p><input type="radio"/> 16 to 18 years old <input type="checkbox"/> Has a learner's permit</p> <p><input type="radio"/> 19 to 21 years old <input type="checkbox"/> Has a graduated license</p> <p><input type="radio"/> 22 to 29 years old <input type="checkbox"/> Has a full license</p> <p><input type="radio"/> 30 to 65 years old <input type="checkbox"/> Has a full license that has been restricted</p> <p><input type="radio"/> &gt;65 years old <input type="checkbox"/> Has a suspended license</p> <p><input type="radio"/> U/K <input type="checkbox"/> Was violating graduated licensing rules</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>		<p>i. Total number of occupants in vehicle responsible for incident:</p> <p><input type="checkbox"/> N/A</p> <p>Total number of occupants: _____ <input type="checkbox"/> U/K</p> <p>Number of teens, ages 14-21: _____ <input type="checkbox"/> U/K</p>	
<p>j. Was a restraint or safety measure used by the child?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, select the restraint or safety measures used:</p> <p><input type="checkbox"/> Lap/shoulder belt</p> <p><input type="checkbox"/> Child seat</p> <p><input type="checkbox"/> Belt positioning booster seat</p> <p><input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> U/K</p> <p>If yes, describe:</p>			
<p><b>H2. FIRE, BURN, OR ELECTROCUTION</b></p>			
<p>a. Ignition, heat or electrocution source:</p> <p><input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning</p> <p><input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Hot bath water</p> <p><input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> U/K</p> <p><input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring</p>		<p>b. Type of incident:</p> <p><input type="radio"/> Fire, go to c</p> <p><input type="radio"/> Scald, go to I1</p> <p><input type="radio"/> Electrocution, go to o</p> <p><input type="radio"/> U/K, go to I1</p>	<p>c. Type of building on fire:</p> <p><input type="radio"/> N/A <input type="radio"/> Trailer/mobile home</p> <p><input type="radio"/> Single home</p> <p><input type="radio"/> Row home/townhouse <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Multi-unit (duplex, apartment, condo) <input type="radio"/> U/K</p>
<p>d. Fire started by a person?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, person's age:</p> <p>If yes, did the person have a history of starting fires?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, suspected arson?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>e. Did any factors delay fire department arrival?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>f. Were barriers preventing safe exit?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Locked/blocked door <input type="checkbox"/> Smoke/fire</p> <p><input type="checkbox"/> Window security bars <input type="checkbox"/> Household items/hoarding</p> <p><input type="checkbox"/> Locked/blocked window</p> <p><input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Trapped above first floor <input type="checkbox"/> U/K</p>	
<p>g. Was the child found in the same location as where the fire started?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>h. Was building a rental property?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Were building/rental codes violated?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe in narrative.</p>	
<p>j. Were proper working fire extinguishers present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>k. Was fire sprinkler system present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>l. Was fire sprinkler system required?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	
<p>m. Were smoke alarms present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Were they functioning properly?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>n. Did the child or family (check all that apply):</p> <p><input type="checkbox"/> None listed below</p> <p><input type="checkbox"/> Have a fire escape plan</p> <p><input type="checkbox"/> Practice a home fire drill</p> <p><input type="checkbox"/> Have two or more possible exits from the location as where the child was found</p> <p><input type="checkbox"/> Attempt to put out the fire</p> <p><input type="checkbox"/> U/K</p>		
<p>o. For electrocution, what cause:</p> <p><input type="radio"/> Lightning/electrical storm <input type="radio"/> Wire/product in water <input type="radio"/> U/K</p> <p><input type="radio"/> Faulty wiring <input type="radio"/> Child playing with outlet</p> <p><input type="radio"/> Contact with power line <input type="radio"/> Other, specify:</p>			

### H3. DROWNING

<p>a. Where was child last seen before drowning? Select one.</p> <p><input type="radio"/> In water</p> <p><input type="radio"/> Near water</p> <p><input type="radio"/> In yard</p> <p><input type="radio"/> In bathroom/tub</p> <p><input type="radio"/> In house</p> <p><input type="radio"/> In car</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>b. Drowning location:</p> <p><input type="radio"/> Open water/pond, go to c</p> <p><input type="radio"/> Pool, hot tub, spa, go to f</p> <p><input type="radio"/> Bathtub, go to l1</p> <p><input type="radio"/> Other, specify and go to h</p> <p><input type="radio"/> U/K, go to h</p>	<p>c. For open water, place:</p> <p><input type="radio"/> Lake      <input type="radio"/> Ocean</p> <p><input type="radio"/> River      <input type="radio"/> Quarry or gravel pit</p> <p><input type="radio"/> Pond      <input type="radio"/> Canal/drainage ditch</p> <p><input type="radio"/> Creek      <input type="radio"/> U/K</p> <p>d. Was child boating?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<p>e. Select all contributing environmental factors. Check all that apply.</p> <p><input type="checkbox"/> None      <input type="checkbox"/> Dropoff</p> <p><input type="checkbox"/> Weather      <input type="checkbox"/> Rough waves</p> <p><input type="checkbox"/> Temperature      <input type="checkbox"/> Flash flood</p> <p><input type="checkbox"/> Current      <input type="checkbox"/> Water clarity</p> <p><input type="checkbox"/> Riptide/undertow   <input type="checkbox"/> U/K</p>
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<p>f. For pool, type of pool:</p> <p><input type="radio"/> Above-ground</p> <p><input type="radio"/> In-ground   <input type="radio"/> Hot tub, spa</p> <p><input type="radio"/> Wading   <input type="radio"/> U/K</p>	<p>g. For pool, ownership is:</p> <p><input type="radio"/> Private</p> <p><input type="radio"/> Public</p> <p><input type="radio"/> U/K</p>	<p>h. Flotation device used at time of the incident?</p> <p><input type="radio"/> N/A      <input type="radio"/> No</p> <p><input type="radio"/> Yes, specify:   <input type="radio"/> U/K</p>	<p>i. Did the child depend on a life jacket, swim vest or swim aid while in or around water?</p> <p><input type="radio"/> N/A   <input type="radio"/> No</p> <p><input type="radio"/> Yes   <input type="radio"/> U/K</p>
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j. Did barriers/layers of protection exist to prevent access to water?       Yes    No    U/K

If yes, check all that apply:

<p><input type="checkbox"/> Fence</p> <p>Was it breached?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Climbed fence</p> <p><input type="checkbox"/> Gap in fence</p> <p><input type="checkbox"/> Damaged fence</p> <p><input type="checkbox"/> Fence too short</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides</p> <p><input type="radio"/> Three sides</p> <p><input type="radio"/> Two or one side</p> <p><input type="radio"/> U/K</p>	<p><input type="checkbox"/> Gate</p> <p>Was it breached?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Gate left open</p> <p><input type="checkbox"/> Gate unlocked</p> <p><input type="checkbox"/> Gate latch failed</p> <p><input type="checkbox"/> Gap in gate</p>	<p><input type="checkbox"/> Door</p> <p>Was it breached?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Door left open</p> <p><input type="checkbox"/> Door unlocked</p> <p><input type="checkbox"/> Door broken</p> <p><input type="checkbox"/> Door screen torn</p> <p><input type="checkbox"/> Door self-closer failed</p>	<p><input type="checkbox"/> Alarm</p> <p>Was it breached?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Alarm not answered</p>	<p><input type="checkbox"/> Cover</p> <p>Was it breached?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Cover not locked</p>
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<p>k. Local ordinance(s) regulating access to water?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, rules violated?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<p>l. Select all of the child's water safety skills (without assistance or flotation device):</p> <p><input type="checkbox"/> None of these      <input type="checkbox"/> Tread water for 1 minute      <input type="checkbox"/> Swim 25 yards</p> <p><input type="checkbox"/> Float on their back      <input type="checkbox"/> Find a safe exit      <input type="checkbox"/> Exit the water</p> <p><input type="checkbox"/> Step or jump into water over their head      <input type="checkbox"/> Control breathing      <input type="checkbox"/> Had swimming lessons</p> <p><input type="checkbox"/> Return to surface      <input type="checkbox"/> U/K</p>	<p>m. Child able to swim?</p> <p><input type="radio"/> N/A   <input type="radio"/> No</p> <p><input type="radio"/> Yes   <input type="radio"/> U/K</p> <p>n. Warning sign or label posted?</p> <p><input type="radio"/> N/A   <input type="radio"/> No</p> <p><input type="radio"/> Yes   <input type="radio"/> U/K</p>
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<p>o. Lifeguard present?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>p. Rescue attempt made?      <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, who? Check all that apply:</p> <p><input type="checkbox"/> Parent/relative      <input type="checkbox"/> EMS/first responder</p> <p><input type="checkbox"/> Other child      <input type="checkbox"/> Bystander</p> <p><input type="checkbox"/> Lifeguard      <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Other adult      <input type="checkbox"/> U/K</p> <p>If yes, did rescuer(s) also drown?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>q. Appropriate rescue equipment present?</p> <p><input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, was it used?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If no, describe:</p>
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### H4. ASPHYXIA

<p>a. Type of event:</p> <p><input type="radio"/> Sleep-related, go to I1</p> <p><input type="radio"/> Not sleep-related, go to b</p> <p><input type="radio"/> U/K, go to b</p>	<p>b. If not sleep-related, was the event:</p> <p><input type="radio"/> Suffocation, go to c</p> <p><input type="radio"/> Strangulation, go to d</p> <p><input type="radio"/> Choking, go to e</p> <p><input type="radio"/> Other, go to I1</p>	<p>c. If suffocation, was the child:</p> <p><input type="radio"/> Covered in or fell into object</p> <p><input type="radio"/> Confined in tight space</p> <p><input type="radio"/> Wedged into tight space, specify:</p> <p><input type="radio"/> Other, specify:</p>
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<p>d. If strangulation, object causing event:</p> <p><input type="radio"/> Clothing      <input type="radio"/> Electrical cord</p> <p><input type="radio"/> Blind cord      <input type="radio"/> Person, go to H5I</p> <p><input type="radio"/> Car seat      <input type="radio"/> Automobile power window or sunroof</p> <p><input type="radio"/> Belt      <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Rope/string</p> <p><input type="radio"/> Leash      <input type="radio"/> U/K</p>	<p>e. If choking, object causing choking:</p> <p><input type="radio"/> Food, specify:</p> <p><input type="radio"/> Toy, specify:</p> <p><input type="radio"/> Vomit/gastric contents</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>f. If choking, was Heimlich Maneuver attempted?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>
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**H5. BODILY FORCE OR WEAPON**

<p>a. Was the death a result of a weapon?</p> <p><input type="radio"/> Yes, go to b</p> <p><input type="radio"/> No, death due to bodily force, go to l</p> <p><input type="radio"/> U/K, go to b</p>	<p>b. Type of weapon:</p> <p><input type="radio"/> Firearm, go to c</p> <p><input type="radio"/> Knife or sharp instrument, go to l</p> <p><input type="radio"/> Rope, go to l</p> <p><input type="radio"/> Other, specify and go to l</p> <p><input type="radio"/> U/K, go to l</p>	<p>c. For firearms, type:</p> <p><input type="radio"/> Handgun</p> <p><input type="radio"/> Shotgun</p> <p><input type="radio"/> Rifle, specify:</p> <p><input type="radio"/> 3D gun</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>e. Was firearm kept loaded?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p> <p>If no, was the ammunition stored locked?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>
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<p>f. Was the firearm kept locked?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>i. Was the person handling the firearm the owner? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Use of weapon at time, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Self injury</td> <td><input type="checkbox"/> Hunting</td> </tr> <tr> <td><input type="checkbox"/> Commission of crime</td> <td><input type="checkbox"/> Target shooting</td> </tr> <tr> <td><input type="checkbox"/> Drug dealing/trading</td> <td><input type="checkbox"/> Playing with weapon</td> </tr> <tr> <td><input type="checkbox"/> Drive-by shooting</td> <td><input type="checkbox"/> Showing gun to others</td> </tr> <tr> <td><input type="checkbox"/> Random violence</td> <td><input type="checkbox"/> Russian roulette</td> </tr> <tr> <td><input type="checkbox"/> Child abuse</td> <td><input type="checkbox"/> Gang-related activity</td> </tr> <tr> <td><input type="checkbox"/> Child was a bystander</td> <td><input type="checkbox"/> Self-defense</td> </tr> <tr> <td><input type="checkbox"/> Argument</td> <td><input type="checkbox"/> Cleaning weapon</td> </tr> <tr> <td><input type="checkbox"/> Jealousy</td> <td><input type="checkbox"/> Loading weapon</td> </tr> <tr> <td><input type="checkbox"/> Intimate partner violence</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Hate crime</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Bullying</td> <td></td> </tr> </table>		<input type="checkbox"/> Self injury	<input type="checkbox"/> Hunting	<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Drug dealing/trading	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Random violence	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Child abuse	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Argument	<input type="checkbox"/> Cleaning weapon	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Hate crime	<input type="checkbox"/> U/K	<input type="checkbox"/> Bullying	
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<input type="checkbox"/> Hate crime	<input type="checkbox"/> U/K																										
<input type="checkbox"/> Bullying																											
<p>g. Did the shooter of the firearm have permission to use the firearm at the time of incident?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>j. Owner of fatal firearm:</p> <p><input type="radio"/> Caregiver</p> <p><input type="radio"/> Other family member</p> <p><input type="radio"/> Child's significant other</p> <p><input type="radio"/> Friend/acquaintance</p> <p><input type="radio"/> Stranger</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>																										
<p>h. Did the caregiver or supervisor know a firearm was present at the time of incident?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>k. Was the firearm stolen?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>																										

m. Type of bodily force used. Check all that apply:

<input type="checkbox"/> Beat, kick or punch	<input type="checkbox"/> Bite	<input type="checkbox"/> Throw	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Drop	<input type="checkbox"/> Shake	<input type="checkbox"/> Drown	
<input type="checkbox"/> Push	<input type="checkbox"/> Strangle/choke	<input type="checkbox"/> Burn	<input type="checkbox"/> U/K

**H6. FALL OR CRUSH**

<p>a. Type:</p> <p><input type="radio"/> Fall, go to b</p> <p><input type="radio"/> Crush, go to g</p>	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <p><input type="checkbox"/> U/K</p>	<p>c. Child fell from:</p> <table border="0"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td><input type="radio"/> U/K</td> </tr> </table>				<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:	<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:	<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass		<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	<input type="radio"/> U/K
<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:																					
<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:																					
<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass																						
<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	<input type="radio"/> U/K																					

<p>d. Surface child fell onto:</p> <p><input type="radio"/> Cement/concrete</p> <p><input type="radio"/> Grass</p> <p><input type="radio"/> Gravel</p> <p><input type="radio"/> Wood floor</p> <p><input type="radio"/> Carpeted floor</p> <p><input type="radio"/> Linoleum/vinyl</p> <p><input type="radio"/> Marble/tile</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Barrier in place, check all that apply::</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Screen</p> <p><input type="checkbox"/> Other window guard</p> <p><input type="checkbox"/> Fence</p> <p><input type="checkbox"/> Railing</p> <p><input type="checkbox"/> Stairway</p> <p><input type="checkbox"/> Gate</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>g. For crush, did child:</p> <p><input type="radio"/> Climb up on object</p> <p><input type="radio"/> Pull object down</p> <p><input type="radio"/> Hide behind object</p> <p><input type="radio"/> Go behind object</p> <p><input type="radio"/> Fall out of object</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>h. For crush, object causing crush:</p> <p><input type="radio"/> Appliance</p> <p><input type="radio"/> Television</p> <p><input type="radio"/> Furniture</p> <p><input type="radio"/> Walls</p> <p><input type="radio"/> Playground equipment</p> <p><input type="radio"/> Animal</p> <p><input type="radio"/> Tree branch</p> <p><input type="radio"/> Boulders/rocks</p> <p><input type="radio"/> Dirt/sand</p> <p><input type="radio"/> Person, go to H5l</p> <p><input type="radio"/> Commercial equipment</p> <p><input type="radio"/> Farm equipment</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>
<p>f. Was child pushed, dropped or thrown?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, go to H5l</p>			

**H7. POISONING, OVERDOSE OR ACUTE INTOXICATION**

a. Type of substance involved, check all that apply and note source, storage, and route of administration of substance:  U/K

<b>Source of Substance</b>	5 = Own prescription (Prescription only)	<b>Stored in locked cabinet?</b>	<b>How substance was taken</b>
1 = Bought from dealer or stranger (Prescription or illicit only)	6 = Bought from store/pharmacy (OTC or other substances only)	Yes	1 = In utero 5 = Through skin
2 = Bought from friend or relative	7 = Other	No	2 = Orally 9 = U/K
3 = From friend or relative for free	9 = U/K	U/K	3 = Nasally
4 = Took from friend or relative without asking			4 = Intravenously

Prescription drug	Source	Stored	Taken	Over-the-counter drug	Source	Stored	Taken
<input type="checkbox"/> Antidepressant/antianxiety		Y	N U	<input type="checkbox"/> Antihistamine		Y	N U
<input type="checkbox"/> Anticonvulsant		Y	N U	<input type="checkbox"/> Cold medicine		Y	N U
<input type="checkbox"/> Antipsychotic		Y	N U	<input type="checkbox"/> Pain medication		Y	N U
<input type="checkbox"/> Benzodiazepines		Y	N U	<input type="checkbox"/> Other OTC, specify:		Y	N U
<input type="checkbox"/> Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)		Y	N U				
<input type="checkbox"/> Non-opioid pain medication		Y	N U				
<input type="checkbox"/> Opioid pain medication (including fentanyl)		Y	N U				
<input type="checkbox"/> Stimulants		Y	N U				
<input type="checkbox"/> Other Rx, specify:		Y	N U				

Was it child's prescription?  Yes  No  U/K

Illicit drugs	Source	Stored	Taken	Other substances	Source	Stored	Taken
<input type="checkbox"/> Cocaine		Y	N U	<input type="checkbox"/> Alcohol		Y	N U
<input type="checkbox"/> Heroin		Y	N U	<input type="checkbox"/> Battery		Y	N U
<input type="checkbox"/> Illicitly manufactured fentanyl/fentanyl analogs		Y	N U	<input type="checkbox"/> Carbon monoxide		Y	N U
<input type="checkbox"/> Marijuana/THC		Y	N U	<input type="checkbox"/> Other fume/gas/vapor		Y	N U
<input type="checkbox"/> Methamphetamine		Y	N U	<input type="checkbox"/> Other, specify:		Y	N U
<input type="checkbox"/> Other, specify:		Y	N U				

b. Was the incident the result of? <input type="radio"/> Accidental overdose/acute intoxication <input type="radio"/> Medical treatment mishap <input type="radio"/> Deliberate poisoning <input type="radio"/> Other, specify: <input type="radio"/> U/K	c. Did the child have a prescription for a controlled substance within the previous 24 months? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Did child have a non-fatal overdose within the previous 12 months? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Was Poison Control contacted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	f. For CO poisoning, was a CO alarm present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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**H8. MEDICAL CONDITION** This section is skipped for fetal deaths\*

a. How long did the child have the medical condition? <input type="radio"/> In utero <input type="radio"/> 1-11 months <input type="radio"/> Since birth <input type="radio"/> >= 1 year <input type="radio"/> < 1 day <input type="radio"/> U/K <input type="radio"/> 1-6 days <input type="radio"/> U/K <input type="radio"/> 7-30 Days	b. Was the death expected as a result of the medical condition? <input type="checkbox"/> N/A, not previously diagnosed <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> But at a later date	c. Was child receiving health care for the medical condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, within 48 hours of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was the care plan appropriate for the medical condition? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, specify:
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d. Did the family experience barriers that prohibited following the care plan? <input type="radio"/> N/A If yes, what treatment components were not completed? Check all that apply. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Appointments <input type="checkbox"/> Other, specify: <input type="checkbox"/> Medications, specify: <input type="checkbox"/> U/K <input type="checkbox"/> Medical equipment use, specify: <input type="checkbox"/> Therapies, specify:	e. In the week prior to the death, did the child experience any changes to medical care? <input type="radio"/> Yes, describe: <input type="radio"/> No <input type="radio"/> U/K
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f. Was the medical condition associated with an outbreak? <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> U/K If yes, was the child vaccinated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	g. Was the death potentially caused by a medical error? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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**H9. OTHER KNOWN INJURY CAUSE**

Specify cause, describe in detail:

**I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS**

**11. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)**

This section displays online based on your state's settings.

Section I1: OMB No. 0920-1092, Exp. Date: 11/30/2028

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

a. Was this death:

- A homicide?
- A suicide?
- An overdose?
- A result of an external cause that was the obvious and only reason for the fatal injury
- Expected within 6 months due to terminal illness?
- None of the above, go to I1b THIS IS AN SDY CASE
- U/K, go to I1b

} If any of these apply, go to Section I2, THIS IS NOT AN SDY CASE.

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death?

**Symptom Present w/in 72 hours of death**

**Cardiac** Yes No U/K

Chest pain

Dizziness/lightheadedness

Fainting

Palpitations

**Neurologic**

Concussion

Confusion

Convulsions/seizure

Headache

Head injury

**Respiratory**

Asthma

Pneumonia

Difficulty breathing

**Other Acute Symptoms**

Fever

Muscle aches/cramping

Vomiting

Other, specify:

c. At any time more than 72 hours preceding death did the child have a personal history of any of the following chronic conditions or symptoms?

**Symptom Present more than 72 hours of death**

**Cardiac** Yes No U/K

Chest pain

Dizziness/lightheadedness

Fainting

Palpitations

**Neurologic**

Concussion

Confusion

Convulsions/seizure

Head injury

**Respiratory**

Difficulty breathing

**Other**

Other, specify:

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

Yes  No  U/K

If yes, describe:

e. Had the child in the past ever been diagnosed by a medical professional for the following?

Condition	Diagnosed			Condition	Diagnosed			Condition	Diagnosed		
	Y	N	U	<b>Cardiac (continued)</b>	Y	N	U	<b>Neurologic (continued)</b>	Y	N	U
<b>Blood disease</b>				High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Neurodegenerative disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sickle cell disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke/mini stroke/	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sickle cell trait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Myocarditis (heart infection)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TIA-Transient Ischemic			
Thrombophilia (clotting disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Attack			
<b>Cardiac</b>	Y	N	U	Sudden cardiac arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Central nervous system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal electrocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>Neurologic</b>	Y	N	U	infection (meningitis			
(EKG or ECG)				Anoxic brain Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	or encephalitis)			
Aneurysm or aortic dilatation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Traumatic brain injury/	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>Respiratory</b>	Y	N	U
Arrhythmia/arrhythmia syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	head injury/concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiomyopathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Brain tumor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congenital heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Brain hemorrhage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary embolism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery abnormality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental brain disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary hemorrhage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocarditis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy/seizure disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Febrile seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								

<b>Condition (continued)</b>	<b>Diagnosed</b>			<b>Diagnosed</b>			<b>Diagnosed</b>				
<u>Other</u>	<u>Y</u>	<u>N</u>	<u>U</u>	<u>Y</u>	<u>N</u>	<u>U</u>	<u>Y</u>	<u>N</u>	<u>U</u>		
Connective tissue disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oncologic disease treated by chemotherapy or radiation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental illness/psychiatric disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prematurity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrine disorder, other: thyroid, adrenal, pituitary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Metabolic disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital disorder/genetic syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing problems or deafness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle disorder or muscular dystrophy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If a more specific diagnosis is known, provide any additional information:											
If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply: <input type="checkbox"/> None											
<input type="checkbox"/> Cardiac ablation			<input type="checkbox"/> Cardiac surgery			<input type="checkbox"/> Heart transplant					
<input type="checkbox"/> Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))			<input type="checkbox"/> Interventional cardiac catheterization			<input type="checkbox"/> Other, specify:			<input type="checkbox"/> U/K		
f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms?							g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?				
<u>Deaths</u>											
<input type="radio"/> <input type="radio"/> <input type="radio"/> Sudden unexpected death before age 50							<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
If yes, the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):							If yes, describe the test/gene tested, reason for testing, family member tested, and results:				
<u>Heart Disease</u>			<u>Symptoms</u>								
<input type="radio"/> <input type="radio"/> <input type="radio"/> Heart condition/heart attack or stroke before age 50			<input type="radio"/> <input type="radio"/> <input type="radio"/> Febrile seizures								
If yes, describe:			<input type="radio"/> <input type="radio"/> <input type="radio"/> Unexplained fainting								
<input type="radio"/> <input type="radio"/> <input type="radio"/> Aortic aneurysm or aortic rupture			<u>Other Diagnoses</u>								
<input type="radio"/> <input type="radio"/> <input type="radio"/> Arrhythmia (fast or irregular heart rhythm)			<input type="radio"/> <input type="radio"/> <input type="radio"/> Congenital deafness								
<input type="radio"/> <input type="radio"/> <input type="radio"/> Cardiomyopathy			<input type="radio"/> <input type="radio"/> <input type="radio"/> Connective tissue disease								
<input type="radio"/> <input type="radio"/> <input type="radio"/> Congenital heart disease			<input type="radio"/> <input type="radio"/> <input type="radio"/> Mitochondrial disease								
<u>Neurologic Disease</u>			<input type="radio"/> <input type="radio"/> <input type="radio"/> Muscle disorder or muscular dystrophy			Was a gene mutation found?					
<input type="radio"/> <input type="radio"/> <input type="radio"/> Epilepsy or convulsions/seizure			<input type="radio"/> <input type="radio"/> <input type="radio"/> Thrombophilia (clotting disorder)			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K					
<input type="radio"/> <input type="radio"/> <input type="radio"/> Other neurologic disease			<input type="radio"/> Other diseases that are genetic or run in families, specify:								
h. In the 72 hours prior to death was the child taking any prescribed medication(s)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K					k. Was the child taking any of the following substance(s) within 24 hours of death?						
If yes, describe:					Check all that apply:						
i. Within 2 weeks prior to death had the child:					<input type="checkbox"/> Over-the-counter medicine			<input type="checkbox"/> Alcohol			
Taken extra doses of prescribed medications <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>					<input type="checkbox"/> Energy drinks			<input type="checkbox"/> Illegal drugs			
Missed doses of prescribed medications <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>					<input type="checkbox"/> Caffeine			<input type="checkbox"/> Legalized marijuana			
Changed prescribed medications, describe: <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>					<input type="checkbox"/> Performance enhancers			<input type="checkbox"/> Other, specify:			
j. Was the child compliant with their prescribed medications?					<input type="checkbox"/> Supplements			<input type="checkbox"/> Tobacco			
<input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K					<input type="checkbox"/> U/K						
If not compliant, describe why and how often:					If yes to any items above, describe:						
l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident?											
<b>Stimuli</b>		<b>At incident</b>			<b>Within 24 hrs of incident</b>						
		<u>Yes</u>	<u>No</u>	<u>U/K</u>	<u>Yes</u>	<u>No</u>	<u>U/K</u>				
Physical activity		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes to physical activity, describe type of activity:			
Sleep deprivation		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	At incident                      Within 24 hours of incident			
Driving		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Visual/video game stimuli		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Emotional stimuli		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Auditory stimuli/startle		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Physical trauma		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other specify:			
Other, specify:		<input type="radio"/>		<input type="radio"/>		<input type="radio"/>		At incident                      Within 24 hours of incident			

<p>m. Was the child an athlete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="padding-left: 40px;">If yes, type of sport: <input type="radio"/> Competitive <input type="radio"/> Recreational <input type="radio"/> U/K</p> <p style="padding-left: 80px;">If competitive, did the child participate in the 6 months prior to death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																																										
<p>n. Did the child ever have any of the following <b>uncharacteristic</b> symptoms during or within 24 hours after physical activity? Check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Chest pain</td> <td><input type="checkbox"/> Palpitations</td> </tr> <tr> <td><input type="checkbox"/> Convulsions/seizure</td> <td><input type="checkbox"/> Shortness of breath/difficulty breathing</td> </tr> <tr> <td><input type="checkbox"/> Dizziness/lightheadedness</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> U/K</td> </tr> </table> <p>If yes to any item, describe type of physical activity and extent of symptoms:</p>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Convulsions/seizure	<input type="checkbox"/> Shortness of breath/difficulty breathing	<input type="checkbox"/> Dizziness/lightheadedness	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Fainting	<input type="checkbox"/> U/K	<p>o. For child age 12 or older, did the child receive a pre-participation exam for a sport? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes:</p> <p>Was it done within a year prior to death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Did the exam lead to restrictions for sports or otherwise? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify restrictions:</p>																																	
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<b>Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)</b>																																										
<p>p. How old was the child when diagnosed with epilepsy/seizure disorder? Age 0 (infant) through 20 years: _____</p> <p><input type="checkbox"/> U/K</p>	<p>r. What type(s) of seizures did the child have? Check all that apply:</p> <p><input type="checkbox"/> Non-convulsive</p> <p><input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure)</p> <p><input type="checkbox"/> Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)</p> <p><input type="checkbox"/> U/K</p>	<p>t. How many seizures did the child have in the year preceding death?</p> <p><input type="radio"/> 0/never <input type="radio"/> 2 <input type="radio"/> More than 3</p> <p><input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> U/K</p>																																								
<p>q. What were the underlying cause(s) of the child's seizures? Check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Brain injury/trauma, specify:</td> <td><input type="checkbox"/> Other acute illness or injury other than epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Brain tumor</td> <td><input type="checkbox"/> Cerebrovascular</td> </tr> <tr> <td><input type="checkbox"/> Central nervous system infection</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Developmental brain disorder</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Genetic/chromosomal</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Idiopathic or cryptogenic</td> <td></td> </tr> </table>	<input type="checkbox"/> Brain injury/trauma, specify:	<input type="checkbox"/> Other acute illness or injury other than epilepsy	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Cerebrovascular	<input type="checkbox"/> Central nervous system infection	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Developmental brain disorder	<input type="checkbox"/> U/K	<input type="checkbox"/> Genetic/chromosomal		<input type="checkbox"/> Idiopathic or cryptogenic		<p>s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:</p> <p><input type="checkbox"/> Last less than 30 minutes</p> <p><input type="checkbox"/> Last more than 30 minutes (status epilepticus)</p> <p><input type="checkbox"/> Occur in the presence of fever (febrile seizure)</p> <p><input type="checkbox"/> Occur in the absence of fever</p> <p><input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)</p>	<p>u. Did treatment for seizures include anti-epileptic drugs? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how many different types of anti-epileptic drugs did the child take?</p> <p><input type="radio"/> 1 <input type="radio"/> 4 <input type="radio"/> More than 6</p> <p><input type="radio"/> 2 <input type="radio"/> 5 <input type="radio"/> U/K</p> <p><input type="radio"/> 3 <input type="radio"/> 6</p>																												
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<input type="checkbox"/> Idiopathic or cryptogenic																																										
<p><b>12. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT*?</b></p> <p style="text-align: right;"><input type="radio"/> Yes, go to l2a <input type="radio"/> No, go to l2t <input type="radio"/> U/K, go to l2a</p>																																										
<p>a. Incident sleep place:</p> <table style="width:100%; border: none;"> <tr> <td><input type="radio"/> Crib</td> <td><input type="radio"/> Adult bed</td> <td><input type="radio"/> Rocking-inclined sleeper</td> <td>If adult bed, what type?</td> <td>If car seat, was car seat secured in seat of car?</td> </tr> <tr> <td style="padding-left: 20px;">If crib, type:</td> <td><input type="radio"/> Waterbed</td> <td><input type="radio"/> Stroller</td> <td><input type="radio"/> Twin</td> <td><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Not portable</td> <td><input type="radio"/> Futon</td> <td><input type="radio"/> Swing</td> <td><input type="radio"/> Full</td> <td></td> </tr> <tr> <td><input type="radio"/> Portable</td> <td><input type="radio"/> Couch</td> <td><input type="radio"/> Bouncy chair</td> <td><input type="radio"/> Queen</td> <td></td> </tr> <tr> <td><input type="radio"/> Unknown crib type</td> <td><input type="radio"/> Chair</td> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> King</td> <td></td> </tr> <tr> <td><input type="radio"/> Bassinet</td> <td><input type="radio"/> Floor</td> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td><input type="radio"/> Bed side sleeper</td> <td><input type="radio"/> Car seat</td> <td></td> <td><input type="radio"/> U/K</td> <td></td> </tr> <tr> <td><input type="radio"/> Baby box</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Rocking-inclined sleeper	If adult bed, what type?	If car seat, was car seat secured in seat of car?	If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Stroller	<input type="radio"/> Twin	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Swing	<input type="radio"/> Full		<input type="radio"/> Portable	<input type="radio"/> Couch	<input type="radio"/> Bouncy chair	<input type="radio"/> Queen		<input type="radio"/> Unknown crib type	<input type="radio"/> Chair	<input type="radio"/> Other, specify:	<input type="radio"/> King		<input type="radio"/> Bassinet	<input type="radio"/> Floor	<input type="radio"/> U/K	<input type="radio"/> Other, specify:		<input type="radio"/> Bed side sleeper	<input type="radio"/> Car seat		<input type="radio"/> U/K		<input type="radio"/> Baby box				
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<p>b. Child put to sleep:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>c. Child found:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>e. Usual sleep position:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>f. Was there any type of crib, portable crib or bassinet in home for child? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																																							
<p>d. Usual sleep place:</p> <table style="width:100%; border: none;"> <tr> <td><input type="radio"/> Crib</td> <td><input type="radio"/> Adult bed</td> <td><input type="radio"/> Rocking-inclined sleeper</td> <td>If adult bed, what type?</td> </tr> <tr> <td style="padding-left: 20px;">If crib, type:</td> <td><input type="radio"/> Waterbed</td> <td><input type="radio"/> Stroller</td> <td><input type="radio"/> Twin <input type="radio"/> King</td> </tr> <tr> <td><input type="radio"/> Not portable</td> <td><input type="radio"/> Futon</td> <td><input type="radio"/> Swing</td> <td><input type="radio"/> Full <input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Portable</td> <td><input type="radio"/> Couch</td> <td><input type="radio"/> Bouncy chair</td> <td><input type="radio"/> Queen <input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Unknown crib type</td> <td><input type="radio"/> Chair</td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td><input type="radio"/> Bassinet</td> <td><input type="radio"/> Floor</td> <td><input type="radio"/> U/K</td> <td></td> </tr> <tr> <td><input type="radio"/> Bed side sleeper</td> <td><input type="radio"/> Car seat</td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Baby box</td> <td></td> <td></td> <td></td> </tr> </table>			<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Rocking-inclined sleeper	If adult bed, what type?	If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Stroller	<input type="radio"/> Twin <input type="radio"/> King	<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Swing	<input type="radio"/> Full <input type="radio"/> Other, specify:	<input type="radio"/> Portable	<input type="radio"/> Couch	<input type="radio"/> Bouncy chair	<input type="radio"/> Queen <input type="radio"/> U/K	<input type="radio"/> Unknown crib type	<input type="radio"/> Chair	<input type="radio"/> Other, specify:		<input type="radio"/> Bassinet	<input type="radio"/> Floor	<input type="radio"/> U/K		<input type="radio"/> Bed side sleeper	<input type="radio"/> Car seat			<input type="radio"/> Baby box											
<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Rocking-inclined sleeper	If adult bed, what type?																																							
If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Stroller	<input type="radio"/> Twin <input type="radio"/> King																																							
<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Swing	<input type="radio"/> Full <input type="radio"/> Other, specify:																																							
<input type="radio"/> Portable	<input type="radio"/> Couch	<input type="radio"/> Bouncy chair	<input type="radio"/> Queen <input type="radio"/> U/K																																							
<input type="radio"/> Unknown crib type	<input type="radio"/> Chair	<input type="radio"/> Other, specify:																																								
<input type="radio"/> Bassinet	<input type="radio"/> Floor	<input type="radio"/> U/K																																								
<input type="radio"/> Bed side sleeper	<input type="radio"/> Car seat																																									
<input type="radio"/> Baby box																																										
<p>g. Child in a new or different environment than usual? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe why:</p>	<p>h. Child last placed to sleep with a pacifier? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Child wrapped or swaddled in blanket when last placed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe:</p>																																								

j. Child overheated?  Yes  No  U/K  
 Check all that apply:  Room too hot, temp \_\_\_\_ degrees F  
 Too much bedding  
 Too much clothing

k. Child exposed to second hand smoke?  
 Yes  No  U/K  
 If yes, how often:  Frequently  U/K  
 Occasionally

l. Child's face when found:  
 Down  
 Up  
 To left or right side  
 U/K

m. Child's neck when found:  
 Hyperextended (head back)  
 Hypoextended (chin to chest)  
 Neutral  
 Turned  
 U/K

n. Child's airway when found (includes nose, mouth, neck and/or chest):  
 Unobstructed by person or object  
 Fully obstructed by person or object  
 Partially obstructed by person or object  
 U/K

If fully or partially obstructed, what was obstructed?  
 Nose  Chest compressed  
 Mouth  U/K  
 Neck compressed  
 If fully or partially obstructed, describe obstruction in detail:

o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	If present, describe position of object:								If present, did object obstruct airway?			→ If adult(s) obstructed airway, describe relationship of adult to child (for example, mother):
	Present?		U/K	On top of child	Under child	Next to child	Tangled around child	U/K	Yes	No	U/K	
	Yes	No										
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fitted sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Nursing or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bottle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Wearable monitor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other(s), specify:	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
_____	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
_____	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

p. Was there a reliable, non-conflicting witness account of how the child was found?  Yes  No  U/K

q. Caregiver/supervisor fell asleep while feeding child?  
 Yes  No  U/K  
 If yes, type of feeding:  Bottle  Breast  U/K

r. Child sleeping in the same room as caregiver/supervisor at time of death?  
 Yes  No  U/K

s. Child sleeping on same surface with person(s) or animal(s)?  
 Yes  No  U/K

If yes, reasons stated for sleeping on same surface, check all that apply:  
 To feed  
 To soothe  
 Usual sleep pattern  
 No infant bed available  
 Home/living space overcrowded  
 Other, specify:  
 U/K

If yes, check all that apply:  
 With adult(s): # \_\_\_\_\_  # U/K  
 Adult obese:  Yes  No  U/K  
 With other children: # \_\_\_\_\_  # U/K Children's ages: \_\_\_\_\_  
 With animal(s): # \_\_\_\_\_  # U/K Type(s) of animal: \_\_\_\_\_  
 U/K

t. Is there a scene re-creation photo available for upload?  Yes  No If yes, upload here. Only one photo allowed.  
 Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

**13. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT\*?**  Yes  No, go to I4  U/K, go to I4

a. Describe product and circumstances:		b. Was product used properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
c. Was a recall in place at the time of the incident? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Did product have safety label? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Were any of the following regulatory agencies notified of the incident? <input type="radio"/> None <input type="radio"/> National Highway Transportation <input type="radio"/> Consumer Product Safety Commission Safety Administration <input type="radio"/> Food and Drug Administration <input type="radio"/> U/K

**14. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME\*?**  Yes  No, go to I5  U/K, go to I5

a. Type of crime, check all that apply:

<input type="checkbox"/> Robbery/burglary	<input type="checkbox"/> Other assault	<input type="checkbox"/> Arson	<input type="checkbox"/> Illegal border crossing	<input type="checkbox"/> U/K
<input type="checkbox"/> Interpersonal violence	<input type="checkbox"/> Gang conflict	<input type="checkbox"/> Sex work	<input type="checkbox"/> Auto theft	
<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Drug trade	<input type="checkbox"/> Witness intimidation	<input type="checkbox"/> Other, specify:	

**15. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS**

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death? <input type="radio"/> Yes/probable <input type="radio"/> No, go to next section <input type="radio"/> U/K, go to next section If yes/probable, choose primary reason: <input type="radio"/> Child abuse, go to I5b <input type="radio"/> Child neglect, go to I5f <input type="radio"/> Poor/absent supervision, go to I5h <input type="radio"/> Exposure to hazards, go to I5g	b. Type of child abuse, check all that apply: <input type="checkbox"/> Abusive head trauma, go to I5c <input type="checkbox"/> Chronic Battered Child Syndrome, go to I5e <input type="checkbox"/> Beating/kicking, go to I5e <input type="checkbox"/> Scalding or burning, go to I5e <input type="checkbox"/> Munchausen Syndrome by Proxy, go to I5e <input type="checkbox"/> Sexual assault, go to I5h <input type="checkbox"/> Other, specify and go to I5h <input type="checkbox"/> U/K, go to I5e	c. For abusive head trauma, were there retinal hemorrhages? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
		d. For abusive head trauma, was the child shaken? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was there impact? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
e. Events(s) triggering child abuse. check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Crying <input type="checkbox"/> Toilet training <input type="checkbox"/> Disobedience <input type="checkbox"/> Feeding problems <input type="checkbox"/> Domestic argument <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	f. Child neglect, check all that apply: <input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <input type="checkbox"/> Failure to provide supervision <input type="checkbox"/> Emotional neglect, specify: <input type="checkbox"/> Abandonment, specify: <input type="checkbox"/> Failure to seek/follow treatment, specify: If yes, was this due to religious or cultural practices? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	g. Exposure to hazards: Do not include child's own behavior. <input type="radio"/> Hazard(s) in sleep environment (including sleep position and surface sharing) <input type="radio"/> Fire hazard <input type="radio"/> Unsecured medication/poison <input type="radio"/> Firearm hazard <input type="radio"/> Water hazard <input type="radio"/> Motor vehicle hazard <input type="radio"/> Mother substance use during pregnancy <input type="radio"/> Other hazard, specify:

h. Was poverty a factor?  Yes  No  U/K If yes, explain in Narrative

**16. SUICIDE**

a. Child's history. Check all that have <u>ever</u> applied: <input type="checkbox"/> None listed below <input type="checkbox"/> Involved in sports <input type="checkbox"/> Involved in activities (not sports) <input type="checkbox"/> Viewed, posted or interacted on social media If yes, specify platform(s): <input type="checkbox"/> History of running away <input type="checkbox"/> History of fearfulness, withdrawal or anxiety <input type="checkbox"/> History of explosive anger, yelling or disobeying <input type="checkbox"/> History of head injury If yes, when was the last head injury? _____ <input type="checkbox"/> Death of a peer, friend or family member If yes, specify relationship to child: _____ When did death occur: _____ Was death a suicide? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	b. Was the child ever diagnosed with any of the following? Check all that apply. <input type="checkbox"/> None listed below <input type="checkbox"/> Anxiety spectrum disorder <input type="checkbox"/> Depressive spectrum disorder <input type="checkbox"/> Bipolar spectrum disorder <input type="checkbox"/> Disruptive, impulse control or conduct disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Substance-related or addictive disorders <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	d. Check all suicidal behaviors/attempts that ever applied: <input type="checkbox"/> None listed below <input type="checkbox"/> Interrupted attempt #__ <input type="checkbox"/> Preparatory behavior #__ <input type="checkbox"/> Non-fatal attempt #__ <input type="checkbox"/> Aborted attempt #__ <input type="checkbox"/> U/K
	c. Did child have a suicide safety plan (a document that helps individuals when experiencing thoughts of suicide to help them avoid intense suicidal crisis)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Did the child <u>ever</u> communicate any suicidal thoughts, actions or intent? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, with whom? _____
g. Did the death occur under circumstances where it would likely be observed and intervened by others? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		

h. Did the child ever have a history of non-suicidal self-harm, such as cutting or burning oneself?  Yes  No  U/K

If yes,  Reported to others  Noted on autopsy  Other, specify:

i. Warning signs ( <a href="https://youthsuicidewarningsigns.org">https://youthsuicidewarningsigns.org</a> ) w/in 30 days of death: Check all that apply: <input type="checkbox"/> None listed below <input type="checkbox"/> Talked about or made plans for suicide <input type="checkbox"/> Expressed hopelessness about the future <input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress <input type="checkbox"/> Expressed perceived burden on others <input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior <input type="checkbox"/> U/K		j. Child experienced a known crisis within 30 days of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, explain:
k. Suicide was part of: <input type="checkbox"/> None listed below <input type="checkbox"/> A cluster <input type="checkbox"/> A contagion, copy-cat or imitation <input type="checkbox"/> A suicide pact <input type="checkbox"/> A murder-suicide		
<b>17. LIFE STRESSORS</b> Please indicate all stressors that were present for this child and family around the time of death.		
a. Life stressors - Social/economic <input type="checkbox"/> None listed below <input type="checkbox"/> Discrimination <input type="checkbox"/> Poverty <input type="checkbox"/> Neighborhood discord <input type="checkbox"/> Job problems <input type="checkbox"/> Money problems <input type="checkbox"/> Food insecurity <input type="checkbox"/> No phone <input type="checkbox"/> Housing instability <input type="checkbox"/> Witnessed violence <input type="checkbox"/> Tobacco exposure <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Cultural differences <input type="checkbox"/> Language barriers <input type="checkbox"/> Lack of child care <input type="checkbox"/> Pregnancy <input type="checkbox"/> Pregnancy scare		
b. Life stressors - Medical <input type="checkbox"/> None listed below <input type="checkbox"/> Lack of family or social support for care <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> Caregiver unskilled in providing care <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Services not available <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Limitations of health insurance <input type="checkbox"/> Provider bias <input type="checkbox"/> Felt dismissed by provider <input type="checkbox"/> Lack of provider-family compatibility		
c. Life Stressors- Relationships <input type="checkbox"/> None listed below <input type="checkbox"/> Family discord <input type="checkbox"/> Argument w/ parents/caregivers <input type="checkbox"/> Parents' divorce/separation <input type="checkbox"/> Parents' incarceration <input type="checkbox"/> Breakup <input type="checkbox"/> Social discord <input type="checkbox"/> Argument with friends <input type="checkbox"/> Isolation <input type="checkbox"/> Bullying as perpetrator <input type="checkbox"/> Cyberbullying as victim <input type="checkbox"/> Cyberbullying as a perpetrator <input type="checkbox"/> Peer violence as a victim		
d. Life stressors - School (age 5 and over) <input type="checkbox"/> None listed below <input type="checkbox"/> School failure <input type="checkbox"/> Pressure to succeed <input type="checkbox"/> Extracurricular activities <input type="checkbox"/> New school <input type="checkbox"/> Other school problems		e. Technology (age 5 and over) <input type="checkbox"/> None listed below <input type="checkbox"/> Electronic gaming <input type="checkbox"/> Texting <input type="checkbox"/> Restriction of technology <input type="checkbox"/> Social media
f. Life stressors - Transitions (age 5 and over) <input type="checkbox"/> None listed below <input type="checkbox"/> Release from hospital <input type="checkbox"/> Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential, etc.) <input type="checkbox"/> Release from juvenile justice facility <input type="checkbox"/> End of school year/school break <input type="checkbox"/> Transition to/from child welfare system <input type="checkbox"/> Release from immigrant detention center		g. Life stressors - Trauma (age 5 and over) <input type="checkbox"/> None listed below <input type="checkbox"/> Rape/sexual assault <input type="checkbox"/> Previous abuse (emotional/physical) <input type="checkbox"/> Family/domestic violence
h. Life stressors - Describe any other life stressors:		
<b>18. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)</b>		
a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply: <input type="checkbox"/> None listed below <input type="checkbox"/> School <input type="checkbox"/> Daycare <input type="checkbox"/> Employment <input type="checkbox"/> Social services (like unemployment assistance, TANF, WIC) <input type="checkbox"/> Living environment <input type="checkbox"/> Medical care <input type="checkbox"/> Mental health or substance use/abuse care <input type="checkbox"/> Home-based services (non-child welfare) <input type="checkbox"/> Child welfare services <input type="checkbox"/> Legal proceedings within criminal, civil, or family courts <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		
b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was the stay at home order in place at the time of the child's death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
c. Was the child exposed to COVID-19 within 14 days of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:		
d. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was the child diagnosed with MIS-C? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
e. Was the child eligible to receive a COVID-19 vaccination? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If eligible, did she receive her first dose? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, approx. number of weeks before death: ____ If eligible and received their first dose, which option best represents their vaccination status? <input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K		
f. For infants or fetal deaths only, did the mother receive her COVID-19 vaccination? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, when did she receive her first dose? <input type="radio"/> Before pregnancy <input type="radio"/> 3rd trimester <input type="radio"/> 1st trimester <input type="radio"/> After delivery <input type="radio"/> 2nd trimester <input type="radio"/> U/K If yes, which option best represents her vaccination status? <input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K		

<p>g. Select the one option that best describes the impact of COVID-19 on this child's death:</p> <p><input type="radio"/> COVID-19 was the immediate or underlying cause of death</p> <p><input type="radio"/> COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19</p> <p><input type="radio"/> COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death</p> <p><input type="radio"/> The mother contracted COVID-19, specify:</p> <p style="margin-left: 20px;"><input type="radio"/> Before pregnancy      <input type="radio"/> 3rd trimester</p> <p style="margin-left: 20px;"><input type="radio"/> 1st trimester            <input type="radio"/> After delivery</p> <p style="margin-left: 20px;"><input type="radio"/> 2nd trimester            <input type="radio"/> U/K</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> COVID-19 had no impact on this child's death</p> <p><input type="radio"/> U/K</p>	<p>h. Did COVID-19 impact the team's ability to conduct this fatality review?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Unable to obtain records</p> <p><input type="checkbox"/> Team members unable to attend review</p> <p><input type="checkbox"/> Remote reviews negatively impacted review process</p> <p><input type="checkbox"/> Team leaders redirected to COVID-19 response</p>
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<b>J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)</b>	This section is skipped for fetal deaths*
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<p>1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?</p> <p><input type="radio"/> Yes/probable</p> <p><input type="radio"/> No, go to K</p> <p><input type="radio"/> U/K, go to K</p>	<p>2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child abuse</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child neglect</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Poor/absent supervision</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Exposure to hazards</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Assault, not child abuse</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Other, specify:</td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>U/K</td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table>	One	Two	One	Two	<input type="radio"/>	<input type="radio"/>	Child abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child neglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Poor/absent supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exposure to hazards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Assault, not child abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	U/K	<input type="radio"/>	<p>3. Did the team have information about the person(s)?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No, go to K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
One	Two	One	Two																																					
<input type="radio"/>	<input type="radio"/>	Child abuse	<input type="radio"/>																																					
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<p>4. Is person listed in a previous section?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes, mother, go to J17</p> <p>Yes, father, go to J17</p> <p>Yes, caregiver one, go to J17</p> <p>Yes, caregiver two, go to J17</p> <p>Yes, supervisor, go to J19</p> <p>No</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>5. Primary person(s) responsible for action(s): Select one for each person responsible.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Adoptive parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Sibling</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Stepparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Other relative</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Foster parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Friend</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Parent's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Acquaintance</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Grandparent</td> <td style="text-align: center;"><input type="radio"/></td> <td 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type="radio"/>	Institutional staff	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Babysitter	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Licensed child care worker	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	U/K
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<p>6. Person's age in years:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> <th style="text-align: center; border-bottom: 1px solid black;"># Years</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">—</td> <td style="text-align: center;">—</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>U/K</td> </tr> </tbody> </table>	One	Two	# Years	—	—		<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>7. Person's sex:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Male</p> <p>Female</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>8. Person speaks and understands English?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p> <p>If no, language spoken:</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>9. Person on active military duty?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p> <p>If yes, specify branch:</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<p>10. Person(s) have history of substance abuse?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>11. Person(s) have history of child maltreatment as victim?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>13. Person(s) have disability or chronic illness?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<p>14. Person(s) have prior child deaths?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>15. Person(s) have history of intimate partner violence?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Yes, as victim</p> <p>Yes, as perpetrator</p> <p>No</p> <p>U/K</p>	One	Two	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>16. Person(s) have delinquent/criminal history?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<p>17. At the time of the incident, was the person asleep?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Yes</p> <p>No</p> <p>U/K</p> <p>If yes, select the most appropriate description of the person's sleeping period at incident:</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">One</th> <th style="text-align: center; border-bottom: 1px solid black;">Two</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Night time sleep</p> <p>Day time nap, describe:</p> <p>Day time sleep (for example, person is night shift worker), describe:</p> <p>Other, describe:</p>	One	Two	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>																		
One	Two																		
<input type="radio"/>	<input type="radio"/>																		
<input type="radio"/>	<input type="radio"/>																		
<input type="radio"/>	<input type="radio"/>																		
<input type="radio"/>	<input type="radio"/>																		



## M. THE REVIEW MEETING PROCESS

1. Date of first review meeting: _____	2. Number of review meetings for this case: _____	3. Is review complete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No
4. Agencies and individuals at review meeting, check all that apply:		
<input type="checkbox"/> Medical examiner/coroner/pathologist	<input type="checkbox"/> CPS	<input type="checkbox"/> Fire
<input type="checkbox"/> Death investigator	<input type="checkbox"/> Other social services	<input type="checkbox"/> EMS
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Physician	<input type="checkbox"/> Faith based organization
<input type="checkbox"/> Prosecutor/district attorney	<input type="checkbox"/> Nurse	<input type="checkbox"/> Education
<input type="checkbox"/> Public health	<input type="checkbox"/> Hospital	<input type="checkbox"/> Mental health
<input type="checkbox"/> HMO/managed care	<input type="checkbox"/> Other health care	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Indian Health Services/ Tribal Health	<input type="checkbox"/> Military	<input type="checkbox"/> Home visiting
<input type="checkbox"/> Healthy Start	<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Court
<input type="checkbox"/> Child advocate	<input type="checkbox"/> Others, list: _____	
5. Were the following data sources available at the review meeting? Check all that apply:	6. Did any of the following factors reduce meeting effectiveness, check all that apply:	
<b>Vital statistics</b>	<input type="checkbox"/> None	
<input type="checkbox"/> Birth certificate - full form	<input type="checkbox"/> Confidentiality issues among members prevented full exchange of information	
<input type="checkbox"/> Death certificate	<input type="checkbox"/> HIPAA regulations prevented access to or exchange of information	
<b>Health records</b>	<input type="checkbox"/> Inadequate investigation precluded having enough information for review	
<input type="checkbox"/> Child's medical records or clinical history	<input type="checkbox"/> Team members did not bring adequate information to the meeting	
<input type="checkbox"/> Hospital records	<input type="checkbox"/> Necessary team members were absent	
<input type="checkbox"/> Mother's obstetric and prenatal information	<input type="checkbox"/> Meeting was held too soon after death	
<input type="checkbox"/> Newborn screening results	<input type="checkbox"/> Meeting was held too long after death	
<input type="checkbox"/> Mental health records	<input type="checkbox"/> Records or information were needed from another locality in-state	
<input type="checkbox"/> Substance abuse treatment records	<input type="checkbox"/> Records or information were needed from another state	
<b>Investigation records</b>	<input type="checkbox"/> Team disagreement on circumstances	
<input type="checkbox"/> Autopsy/pathology reports	<input type="checkbox"/> Other factors, specify: _____	
<input type="checkbox"/> CDC's SUIDI Reporting Form		
<input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form		
<input type="checkbox"/> Law enforcement records		
<input type="checkbox"/> Social service records		
<input type="checkbox"/> Child protection agency records		
<input type="checkbox"/> EMS run sheet		
<b>Other</b>		
<input type="checkbox"/> Home visiting		
<input type="checkbox"/> School records		
7. Review meeting outcomes, check all that apply:		
<input type="checkbox"/> Team disagreed with official manner of death. What did team believe manner should be?		
<input type="checkbox"/> Team disagreed with official cause of death. What did team believe cause should be?		
<input type="checkbox"/> Because of the review, the official cause or manner of death was changed		

## N. SUID AND SDY CASE REGISTRY

This section displays online based on your state's settings.

Section N: OMB No. 0920-1092, Exp. Date: 11/30/2028

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

1. Is this an SDY or SUID case? <input type="radio"/> Yes <input type="radio"/> No	If no, go to Section O
2. Did this case go to Advanced Review for the SUID and SDY Case Registry? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No If yes, date of first Advanced Review meeting: _____	3. Notes from Advanced Review meeting (include case details that helped determine SDY categorization and any ways to improve the review) or reason why case did not go to Advanced Review:  _____
4. Professionals at the Advanced Review meeting, check all that apply:	
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Death investigator
<input type="checkbox"/> CDR representative	<input type="checkbox"/> Epileptologist
<input type="checkbox"/> Coroner	<input type="checkbox"/> Forensic pathologist/medical examiner
<input type="checkbox"/> Geneticist or genetic counselor	<input type="checkbox"/> Pediatrician
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Public health representative
<input type="checkbox"/> Neonatologist	<input type="checkbox"/> Others, specify: _____
5. Did the Advanced Review team believe the autopsy was comprehensive? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

<p>7. Was a specimen saved for the SUID and SDY Case Registry?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>9. Did the family consent to have DNA saved as part of the SUID and SDY Case Registry?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If no, why not? <input type="radio"/> Consent was not attempted  <input type="radio"/> Consent was attempted but follow up was unsuccessful  <input type="radio"/> Consent was attempted but family declined  <input type="radio"/> Other, specify:</p>
<p>8. Was a specimen sent to the SUID and SDY Case Registry Biorepository?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	

10. Select an SDY category per the SUID and SDY Case Registry SDY algorithm (choose only one):

<input type="radio"/> Excluded	<input type="radio"/> Explained - Neurological, specify:	<input type="radio"/> Explained - Other, specify:	<input type="radio"/> Unexplained - Sudden
<input type="radio"/> Unexplained - Incomplete Case Information	<input type="radio"/> Explained - Suffocation with Unsafe Sleep Factors (under age 1)	<input type="radio"/> Unexplained - Possible Cardiac and Sudden Unexpected Death in a Child with Epilepsy/Seizure Disorder	<input type="radio"/> Unexplained - Possible Cardiac and Sudden Unexpected Death in a Child with Epilepsy/Seizure Disorder
<input type="radio"/> Explained - Cardiac, specify:			<input type="radio"/> Unexplained

11. Select a SUID category per the SUID and SDY Case Registry SUID algorithm (choose only one):

<input type="radio"/> Excluded <input type="radio"/> Unexplained - No Autopsy or Death Investigation <input type="radio"/> Unexplained - Incomplete Case Information <input type="radio"/> Unexplained - No Unsafe Sleep Factors <input type="radio"/> Unexplained - Unsafe Sleep Factors <input type="radio"/> Unexplained - Possible Suffocation with Unsafe Sleep Factors <input type="radio"/> Explained - Suffocation with Unsafe Sleep Factors	If Unexplained - Possible Suffocation or Explained - Suffocation, select the airway obstruction mechanism(s), check all that apply: <input type="checkbox"/> Soft bedding <input type="checkbox"/> Wedging <input type="checkbox"/> Overlay <input type="checkbox"/> Other, specify:
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**O. NARRATIVE**

**O1. NARRATIVE**

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information. **DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, dates, addresses, and specific service providers.** Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death? The Narrative is included in de-identified downloads, and per MPH/NCFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.

**P. FORM COMPLETED BY:**

Person:	Email:
Title:	Date completed:
Agency:	Data entry completed for this case? <input type="checkbox"/>
Phone:	
	<b>For State Program Use Only:</b> Data quality assurance completed by state? <input type="checkbox"/>



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