

# FIMR REPORT FORM

*Version 6.0*

## **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)

[ncfrp.org](http://ncfrp.org)



[@nationalcfrp](https://twitter.com/nationalcfrp)



# SAVING LIVES TOGETHER

## Instructions:

This case report is used by Fetal and Infant Mortality Review (FIMR) 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 FIMR 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 it 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 Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) 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)			Death Certificate Number:  Birth Certificate Number:  ME/Coroner Number:			
				<input type="checkbox"/> Child never left hospital following birth			Date Team Notified of Death:			
A. CHILD INFORMATION										
A1. CHILD INFORMATION (COMPLETE FOR ALL AGES) <span style="float:right">A + symbol means that the question is skipped for fetal deaths.</span>										
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"/> American Indian, Tribe: _____  <input type="checkbox"/> Asian, specify: _____  <input type="checkbox"/> Black  <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander, specify: _____  <input type="checkbox"/> White <input type="checkbox"/> U/K			6. Hispanic or Latino/a origin?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		7. Sex:  <input type="radio"/> Male <input type="radio"/> Female <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										
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:			
				10. Child's height at death+: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ <input type="radio"/> Cm _____			12. County 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				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 A3.										
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		22. Number of other children living with child:  _____ <input type="checkbox"/> U/K		
						21. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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, how was history identified: If yes, check all that apply: <input type="radio"/> Through CPS <input type="checkbox"/> Physical <input type="radio"/> Other sources <input type="checkbox"/> Neglect                                If through CPS: <input type="checkbox"/> Sexual                                _____ # CPS referrals <input type="checkbox"/> Emotional/psychological        _____ # Substantiations <input type="checkbox"/> U/K						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? _____				
A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR <span style="float:right">Questions 27 - 42 (Section A2) are intentionally skipped; + means skipped for fetal deaths.</span>										
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:  <input type="checkbox"/> U/K _____ # weeks		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 childbearing parent have? # ____ <input type="checkbox"/> U/K			
48. Including the deceased infant, how many live births did the childbearing parent have? # _____ <input type="checkbox"/> U/K										
49. Not including the deceased infant, number of children childbearing parent 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, month of first prenatal visit. Specify 1-9: _____ <input type="checkbox"/> U/K						

51. Were there access or barrier issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K    If yes, check all that apply: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Lack of money for care</div> <div style="width: 33%;"><input type="checkbox"/> Couldn't get provider to take as patient</div> <div style="width: 33%;"><input type="checkbox"/> Services not available</div> <div style="width: 33%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 33%;"><input type="checkbox"/> Limitations of health insurance coverage</div> <div style="width: 33%;"><input type="checkbox"/> Multiple providers, not coordinated</div> <div style="width: 33%;"><input type="checkbox"/> Distrust of health care system</div> <div style="width: 33%;"><input type="checkbox"/> Lack of transportation</div> <div style="width: 33%;"><input type="checkbox"/> Couldn't get an earlier appointment</div> <div style="width: 33%;"><input type="checkbox"/> Unwilling to obtain care</div> <div style="width: 33%;"><input type="checkbox"/> U/K</div> <div style="width: 33%;"><input type="checkbox"/> Cultural differences</div> <div style="width: 33%;"><input type="checkbox"/> Lack of child care</div> <div style="width: 33%;"><input type="checkbox"/> Didn't know where to go</div> <div style="width: 33%;"><input type="checkbox"/> Language barriers</div> <div style="width: 33%;"><input type="checkbox"/> Lack of family/social support</div> <div style="width: 33%;"><input type="checkbox"/> Didn't think they were pregnant</div> </div>			
53. Did the childbearing parent 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)			
54. Did the childbearing parent 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: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Over-the-counter meds</div> <div style="width: 25%;"><input type="checkbox"/> Anti-epileptic</div> <div style="width: 25%;"><input type="checkbox"/> Nausea/vomiting medications</div> <div style="width: 25%;"><input type="checkbox"/> Cocaine</div> <div style="width: 25%;"><input type="checkbox"/> Meds to treat drug addiction</div> <div style="width: 25%;"><input type="checkbox"/> Allergy medications</div> <div style="width: 25%;"><input type="checkbox"/> Anti-hypertensives</div> <div style="width: 25%;"><input type="checkbox"/> Cholesterol medications</div> <div style="width: 25%;"><input type="checkbox"/> Heroin</div> <div style="width: 25%;"><input type="checkbox"/> Opioids</div> <div style="width: 25%;"><input type="checkbox"/> Antibiotics</div> <div style="width: 25%;"><input type="checkbox"/> Anti-hypothyroidism</div> <div style="width: 25%;"><input type="checkbox"/> Meds to treat preterm labor</div> <div style="width: 25%;"><input type="checkbox"/> Marijuana</div> <div style="width: 25%;"><input type="checkbox"/> Other pain meds</div> <div style="width: 25%;"><input type="checkbox"/> Anti-depressants/</div> <div style="width: 25%;"><input type="checkbox"/> Arthritis medications</div> <div style="width: 25%;"><input type="checkbox"/> Meds used during delivery</div> <div style="width: 25%;"><input type="checkbox"/> Methamphetamine</div> <div style="width: 25%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 25%;"><input type="checkbox"/> anti-anxiety/</div> <div style="width: 25%;"><input type="checkbox"/> Diabetes medications</div> <div style="width: 25%;"><input type="checkbox"/> Progesterone/P17</div> <div style="width: 25%;"><input type="checkbox"/> Alcohol</div> <div style="width: 25%;"><input type="checkbox"/> U/K</div> <div style="width: 25%;"><input type="checkbox"/> anti-psychotics</div> <div style="width: 25%;"><input type="checkbox"/> Asthma medications</div> <div style="width: 25%;"><input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome?</div> </div> If any item is checked, please indicate the generic or brand name of the medications or drugs:			
55. Was the infant/fetus delivered drug expos <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		56. Did the infant have neonatal abstinence syndrome (NAS)*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
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	58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent? <input type="radio"/> N/A, childbearing parent did not go to a birth hospital <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
	59. Did the childbearing parent have contact with their care provider within the first 3 weeks postpartum? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
	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: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Prematurity</div> <div style="width: 25%;"><input type="checkbox"/> Apnea</div> <div style="width: 25%;"><input type="checkbox"/> Hypothermia</div> <div style="width: 25%;"><input type="checkbox"/> Meconium aspiration</div> <div style="width: 25%;"><input type="checkbox"/> Low birth weight</div> <div style="width: 25%;"><input type="checkbox"/> Sepsis</div> <div style="width: 25%;"><input type="checkbox"/> Jaundice</div> <div style="width: 25%;"><input type="checkbox"/> Congenital anomalies</div> <div style="width: 25%;"><input type="checkbox"/> Tachypnea</div> <div style="width: 25%;"><input type="checkbox"/> Feeding difficulties</div> <div style="width: 25%;"><input type="checkbox"/> Anemia</div> <div style="width: 25%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 25%;"><input type="checkbox"/> Drug/alcohol exposure</div> <div style="width: 25%;"><input type="checkbox"/> U/K</div> </div>		
61. Did the childbearing parent smoke in the 3 months before pregnancy? <input type="radio"/> Yes    If yes, ____ Avg # cigarettes/day <input type="radio"/> No    (20 cigarettes in pack) <input type="radio"/> U/K <input type="checkbox"/> U/K quantity		62. Did the childbearing parent smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <div style="display: flex; justify-content: space-around;"> <div> <u>Trimester 1</u>  If yes, ____  <input type="checkbox"/> U/K quantity </div> <div> <u>Trimester 2</u>  If yes, ____  <input type="checkbox"/> U/K quantity </div> <div> <u>Trimester 3</u>  If yes, ____  <input type="checkbox"/> U/K quantity </div> </div>	
63. Did the childbearing parent 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			
64. Was the childbearing parent injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K    If yes, describe:		65. Did the childbearing parent have postpartum depression? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
If this was a fetal death, go to Section A4.			
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		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:	
If the infant never left the hospital following birth, go to Section A4.			
68. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Cyanosis</div> <div style="width: 50%;"><input type="checkbox"/> Infection</div> <div style="width: 50%;"><input type="checkbox"/> Seizures or convulsions</div> <div style="width: 50%;"><input type="checkbox"/> Allergies</div> <div style="width: 50%;"><input type="checkbox"/> Cardiac abnormalities</div> <div style="width: 50%;"><input type="checkbox"/> Abnormal growth, weight gain/loss</div> <div style="width: 50%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 50%;"><input type="checkbox"/> Apnea</div> <div style="width: 50%;"><input type="checkbox"/> U/K</div> </div>		69. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> None</div> <div style="width: 33%;"><input type="checkbox"/> Decrease in appetite</div> <div style="width: 33%;"><input type="checkbox"/> Apnea</div> <div style="width: 33%;"><input type="checkbox"/> Fever</div> <div style="width: 33%;"><input type="checkbox"/> Vomiting</div> <div style="width: 33%;"><input type="checkbox"/> Cyanosis</div> <div style="width: 33%;"><input type="checkbox"/> Excessive sweating</div> <div style="width: 33%;"><input type="checkbox"/> Choking</div> <div style="width: 33%;"><input type="checkbox"/> Seizures or convulsions</div> <div style="width: 33%;"><input type="checkbox"/> Lethargy/sleeping more than usual</div> <div style="width: 33%;"><input type="checkbox"/> Diarrhea</div> <div style="width: 33%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 33%;"><input type="checkbox"/> Stool changes</div> <div style="width: 33%;"><input type="checkbox"/> Fussiness/excessive crying</div> <div style="width: 33%;"><input type="checkbox"/> Difficulty breathing</div> <div style="width: 33%;"><input type="checkbox"/> U/K</div> </div>	

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:	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:	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:	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																																																																																																																				
<b>A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR</b> <span>A + symbol means that the question is skipped for fetal deaths.</span>																																																																																																																							
74. Name of childbearing biological parent (CBP): First: Middle: Last: Maiden: <input type="checkbox"/> U/K																																																																																																																							
75. Name of non-childbearing biological parent (Non-CBP): First: Middle: Last: <input type="checkbox"/> U/K																																																																																																																							
76. Childbearing parent's country of birth: <input type="checkbox"/> U/K		77. Non-childbearing biological parent's country of birth: <input type="checkbox"/> U/K																																																																																																																					
78. Childbearing parent's residence address: <input type="checkbox"/> Same as child Street: <input type="checkbox"/> U/K Apt. City: State: Zip: County:		79. Childbearing parent's marital status during pregnancy: <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> U/K	80. Number of months between <input type="checkbox"/> U/K prior pregnancy and this one: 81. Was childbearing parent taking folic acid or a multivitamin prior to this pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																				
82. Childbearing parent's employment during pregnancy: <input type="radio"/> Employed If employed, did they think it was physically hard? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Unemployed <input type="radio"/> On disability If employed, did they think the job was stressful? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Stay-at-home <input type="radio"/> Student If employed or student, number of weeks post-delivery started or returned: <input type="radio"/> U/K If employed or student, who watched the infant? Describe:		83. Childbearing parent's pre-pregnancy weight, height, BMI: Weight in pounds (whole number): lbs <input type="checkbox"/> U/K Height in feet and inches (whole numbers): ft in <input type="checkbox"/> U/K BMI will be calculated automatically if both height and weight are available. If you don't have height and weight but know the pre-pregnancy BMI, you can enter it: 84. Childbearing parent's pregnancy weight gain or loss in pounds (whole number) Enter a negative number for weight loss: lbs <input type="checkbox"/> U/K 85. Did childbearing parent achieve the recommended weight gain? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																					
86. Childbearing parent's age at first pregnancy: <input type="checkbox"/> U/K																																																																																																																							
87. For each previous pregnancy, describe most recent first: <input type="checkbox"/> N/A <span>*Outcome Codes: 1 - Full-term, live birth</span>																																																																																																																							
<table><tr><th>Preg #</th><th># in gest. (twins=2)</th><th>Baby A, B, C, etc</th><th>Year of Delivery</th><th>CBP Age</th><th>Gestational age in weeks</th><th>Birth weight (grams)</th><th colspan="4">Choose one:</th><th>Outcome Code*</th></tr><tr><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>NSVD</th><th>C-Sec</th><th>VBAC</th><th>Other</th><th></th></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td></td></tr></table>											Preg #	# in gest. (twins=2)	Baby A, B, C, etc	Year of Delivery	CBP Age	Gestational age in weeks	Birth weight (grams)	Choose one:				Outcome Code*								NSVD	C-Sec	VBAC	Other									Y	Y	Y	Y									Y	Y	Y	Y									Y	Y	Y	Y									Y	Y	Y	Y									Y	Y	Y	Y									Y	Y	Y	Y									Y	Y	Y	Y		2 - Premature live birth 3 - Stillbirth > or = 20 weeks 4 - Spontaneous abortion/ miscarriage/ Stillbirth < 20 weeks 5 - Therapeutic abortion 6 - Voluntary abortion 7 - Ectopic 9 - U/K
Preg #	# in gest. (twins=2)	Baby A, B, C, etc	Year of Delivery	CBP Age	Gestational age in weeks	Birth weight (grams)	Choose one:				Outcome Code*																																																																																																												
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88. Was childbearing parent using birth control in the 3 months prior to this pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what type? <input type="radio"/> LARC including implants/IUDs <input type="radio"/> Natural, withdrawal, pull out, rhythm method <input type="radio"/> Oral contraceptives, specify: <input type="radio"/> Tubal ligation <input type="radio"/> Barrier methods (male/female condoms/cervical cap) <input type="radio"/> Multiple methods <input type="radio"/> Injections (Depo Provera) <input type="radio"/> Other, specify: <input type="radio"/> Spermicides <input type="radio"/> U/K If no, was pregnancy: <input type="radio"/> Unintended <input type="radio"/> Intended <input type="radio"/> Mistimed <input type="radio"/> U/K						89. Where was prenatal care most frequently provided for this pregnancy? <input type="radio"/> N/A <input type="radio"/> Private provider's office <input type="radio"/> County or city health department <input type="radio"/> Clinic <input type="radio"/> Managed care organization <input type="radio"/> Community/neighborhood health center <input type="radio"/> Other, specify type: <input type="radio"/> U/K		90. Which type of provider most frequently provided prenatal care for this pregnancy? <input type="radio"/> N/A <input type="radio"/> Nurse practitioner <input type="radio"/> OB <input type="radio"/> Nurse midwife <input type="radio"/> Perinatologist <input type="radio"/> Family physician <input type="radio"/> Other, specify type: <input type="radio"/> U/K																																																																																																															
91. Was this pregnancy a result of assisted reproductive technology? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:																																																																																																																							

<u>Performed</u>	<u>Normal/Abnormal?</u>	<u>Performed</u>	<u>Normal/Abnormal?</u>	<u>Performed</u>	<u>Positive or negative?</u>
Y N U/K	N A U/K	Y N U/K	N A U/K	Y N U/K	P N U/K
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> CBC	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Measurement of cervical length	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Antibody screen
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> GTT	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Maturity (L/S ratio)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> STI culture or test
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> HCT/HGB	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Pap smear	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Urine toxicology
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Quad screen, specify abnormal results:	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Sickle prep or equivalent		Positive for what?
	<u>Antepartum fetal surveillance</u>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Ultrasound	<u>Performed</u>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Fetal movement assessment (kick counts)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> TORCH	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Blood type and Rh factor
		<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Urine culture		If yes, what was blood type?
		<u>Performed</u>			If yes, was CBP Rh negative?
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Contraction stress test	<input type="radio"/> <input type="radio"/> <input type="radio"/> Rubella titer			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Nonstress test	If Rubella titer performed	<input type="radio"/> Immune	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Other, specify test and results (abnormal/positive/etc.):
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Biophysical profile		<input type="radio"/> Not immune		
			<input type="radio"/> U/K		

94. During this pregnancy and including any previous pregnancies, did the childbearing parent have any medical conditions/complications?

☐ Yes   ☐ No   ☐ U/K

Timeframe	Referrals during this pregnancy
1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy	1 - No referral, not needed
2 - Began previous to this pregnancy AND includes current pregnancy	2 - No referral, already in care
3 - Began during this current pregnancy	3 - No referral, needed
4 - Began during labor and delivery	4 - Referral made, services not provided
9 - U/K	5 - Referral made, services provided
	9 - U/K

<u>Cardiovascular</u>	Timeframe	Referral	<u>Gynecologic</u>	Timeframe	Referral
<input type="checkbox"/> Hypertension - gestational	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Uterine/vaginal bleeding	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Hypertension - chronic	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Chorioamnionitis	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Pre-eclampsia	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Oligohydramnios	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Eclampsia	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Polyhydramnios	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Clotting disorder	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Intrauterine growth restriction (IUGR)	<input type="text"/>	<input type="text"/>
<u>Hematologic</u>			<input type="checkbox"/> Premature rupture of membranes (PROM)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Sickle cell disease	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Preterm premature rupture of membranes (PPROM)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Anemia (iron deficiency)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Cervical Insufficiency	<input type="text"/>	<input type="text"/>
<u>Respiratory</u>			<u>Umbilical cord complications</u>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Asthma	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Prolapse	<input type="text"/>	<input type="text"/>
<u>Endocrine/Metabolic</u>			<input type="checkbox"/> Nuchal cord	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Diabetes, type 1 chronic	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Other cord, specify:	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Diabetes, type 2 chronic	<input type="text"/>	<input type="text"/>	<u>Placental problems</u>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Diabetes, gestational	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Abrupton	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Thyroid	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Previa	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Polycystic ovarian disease	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Other placental, specify:		
<u>Neurologic/Psychiatric</u>			<u>Other Complications/Conditions</u>		
<input type="checkbox"/> Addiction disorder	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> UTI	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Depression	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Decreased fetal movement	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Anxiety disorder	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> HELLP syndrome	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Seizure disorder	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> CBP developmental delay	<input type="text"/>	<input type="text"/>
<u>Sexually Transmitted Infections (STI)</u>			<input type="checkbox"/> Oral health/dental or gum infection	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Bacterial vaginosis (BV)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Gastrointestinal	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Chlamydia	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> CBP genetic disorder	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Gonorrhea	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Abnormal MSAFP	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Herpes	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Preterm labor	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> HPV	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Obesity	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Syphilis	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Other, specify:	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Group B strep	<input type="text"/>	<input type="text"/>			
<input type="checkbox"/> HIV/AIDS	<input type="text"/>	<input type="text"/>			
<input type="checkbox"/> Other STI, specify:	<input type="text"/>	<input type="text"/>			



<p>95. Did the care provider recommend precautions to prevent premature labor or early labor? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p style="margin-left: 40px;">If yes, what precautions? <span style="float: right;">If yes for a precaution, was there a barrier or system issue that prevented the advice from being followed?</span></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Took medicine to prevent labor or miscarriage  <input type="checkbox"/> Received progesterone IM or vaginal progesterone  <input type="checkbox"/> Stopped or limited sex during pregnancy  <input type="checkbox"/> Used condoms to prevent infection  <input type="checkbox"/> Placement of cervical cerclage  <input type="checkbox"/> Had bed rest for one or more weeks at home  <input type="checkbox"/> Was hospitalized for one or more nights  <input type="checkbox"/> Reduced work hours or stopped working earlier than expected  <input type="checkbox"/> Reduced housework or other physical activities  <input type="checkbox"/> Other, specify: </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </td> </tr> </table>				<input type="checkbox"/> Took medicine to prevent labor or miscarriage <input type="checkbox"/> Received progesterone IM or vaginal progesterone <input type="checkbox"/> Stopped or limited sex during pregnancy <input type="checkbox"/> Used condoms to prevent infection <input type="checkbox"/> Placement of cervical cerclage <input type="checkbox"/> Had bed rest for one or more weeks at home <input type="checkbox"/> Was hospitalized for one or more nights <input type="checkbox"/> Reduced work hours or stopped working earlier than expected <input type="checkbox"/> Reduced housework or other physical activities <input type="checkbox"/> Other, specify:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																						
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<p>96. Type of delivery:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Routine  <input type="checkbox"/> Emergency  <input type="checkbox"/> Normal spontaneous vaginal delivery (NSVD)  <input type="checkbox"/> Vaginal, induced or augmented </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Vaginal delivery after C-Section (VBAC)  <input type="checkbox"/> C-Section  <input type="checkbox"/> Forceps  <input type="checkbox"/> Vacuum extraction  <input type="checkbox"/> U/K </td> <td style="width: 33%; vertical-align: top;"> <p>If C-Section, why was it done?</p> <input type="checkbox"/> Failure to progress  <input type="checkbox"/> Fetal distress  <input type="checkbox"/> Macrosomia  <input type="checkbox"/> Placental abruption  <input type="checkbox"/> Placental Previa  <input type="checkbox"/> Malpresentation  <input type="checkbox"/> Repeat C-Section  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K </td> </tr> </table>		<input type="checkbox"/> Routine <input type="checkbox"/> Emergency <input type="checkbox"/> Normal spontaneous vaginal delivery (NSVD) <input type="checkbox"/> Vaginal, induced or augmented	<input type="checkbox"/> Vaginal delivery after C-Section (VBAC) <input type="checkbox"/> C-Section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> U/K	<p>If C-Section, why was it done?</p> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetal distress <input type="checkbox"/> Macrosomia <input type="checkbox"/> Placental abruption <input type="checkbox"/> Placental Previa <input type="checkbox"/> Malpresentation <input type="checkbox"/> Repeat C-Section <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																																							
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<p>97. Were there any signs of fetal distress? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, specify:</p>	<p>100. Was there evidence of injury at death, not including the birth process*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, what type(s) of injury?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Contusion/bruises  <input type="checkbox"/> Fractures  <input type="checkbox"/> Cigarette burns  <input type="checkbox"/> Hemorrhage </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Abrasions/scratches  <input type="checkbox"/> Resuscitative marks  <input type="checkbox"/> Other, specify: </td> </tr> </table>	<input type="checkbox"/> Contusion/bruises <input type="checkbox"/> Fractures <input type="checkbox"/> Cigarette burns <input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Abrasions/scratches <input type="checkbox"/> Resuscitative marks <input type="checkbox"/> Other, specify:	<p>101. Was a placental pathology performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, describe findings:</p>																																							
<input type="checkbox"/> Contusion/bruises <input type="checkbox"/> Fractures <input type="checkbox"/> Cigarette burns <input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Abrasions/scratches <input type="checkbox"/> Resuscitative marks <input type="checkbox"/> Other, specify:																																										
<p>98. Were any birth defects noted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, specify:</p>		<p>99. Date of childbearing parent's discharge from the birth hospital:</p> <div style="display: flex; align-items: center; margin-left: 40px;"> <div style="border-bottom: 1px solid black; width: 100px; margin-right: 10px;"></div> <div style="border-bottom: 1px solid black; width: 100px; margin-right: 10px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div> </div> <div style="display: flex; align-items: center; margin-left: 40px;"> <div>mm / dd / yyyy</div> <div style="margin-left: 20px;"><input type="radio"/> N/A <input type="radio"/> U/K</div> </div>																																									
<p>102. Payer source for childbearing parent's care for the following timeframes, check all that apply:</p> <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Pre</u></th> <th style="text-align: center;"><u>Preg</u></th> <th style="text-align: center;"><u>L&amp;D</u></th> <th style="text-align: center;"><u>Post</u></th> </tr> </thead> <tbody> <tr> <td>None</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Private insurance</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Medicaid</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>State plan</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Indian Health Service</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other, specify:</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>U/K</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> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			<u>Pre</u>	<u>Preg</u>	<u>L&amp;D</u>	<u>Post</u>	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Private insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	State plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>103. Did the childbearing parent have stable housing during the pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If no, indicate the type(s) of instability:</p> <input type="checkbox"/> Parent in jail <input type="checkbox"/> Homeless <input type="checkbox"/> Eviction(s) <input type="checkbox"/> More than 3 moves in past year <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	
	<u>Pre</u>	<u>Preg</u>	<u>L&amp;D</u>	<u>Post</u>																																							
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U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
<p>104. Did the childbearing parent have phone service during the pregnancy?</p> <input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always <input type="radio"/> U/K																																											
<p>105. Did the childbearing parent have any high-risk prenatal/ antepartum encounters? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, number of visits with primary care provider: _____</p> <p style="margin-left: 40px;">If yes, number of L&amp;D/triage/ED visits, excluding the birth: _____</p>		<p>106. Did the childbearing parent have any hospitalizations greater than 24 hours prior to labor and delivery excluding the birth? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p style="margin-left: 40px;">If yes, what treatment was recommended?</p>																																									
<p>107. Did childbearing parent die as a result of a pregnancy related condition? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p>																																											
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<p>109. Were any health education topics discussed at any time between the first prenatal care visit and the delivery? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p style="margin-left: 40px;">If yes, which topic(s)?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent  <input type="checkbox"/> Where to go for care in case of emergency  <input type="checkbox"/> Current medications  <input type="checkbox"/> Environmental/work hazards  <input type="checkbox"/> Childbearing parent nutrition  <input type="checkbox"/> Weight gain counseling  <input type="checkbox"/> Eating disorders such as anorexia or bulimia  <input type="checkbox"/> Exercise  <input type="checkbox"/> Labor signs </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Signs and symptoms of pregnancy-induced hypertension  <input type="checkbox"/> HIV testing  <input type="checkbox"/> Childbearing parent's vaccinations  <input type="checkbox"/> Risk factors identified by prenatal history  <input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange)  <input type="checkbox"/> Illicit/recreational drugs  <input type="checkbox"/> Fetal movement monitoring  <input type="checkbox"/> Kick counts  <input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Preparing to breastfeed  <input type="checkbox"/> Safe sleep education  <input type="checkbox"/> Importance of keeping postpartum visits  <input type="checkbox"/> Postpartum (perinatal) depression  <input type="checkbox"/> Family planning (spacing, interconception care, etc.)  <input type="checkbox"/> Postpartum family planning/tubal sterilization  <input type="checkbox"/> Other, specify: </td> </tr> </table>				<input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent <input type="checkbox"/> Where to go for care in case of emergency <input type="checkbox"/> Current medications <input type="checkbox"/> Environmental/work hazards <input type="checkbox"/> Childbearing parent nutrition <input type="checkbox"/> Weight gain counseling <input type="checkbox"/> Eating disorders such as anorexia or bulimia <input type="checkbox"/> Exercise <input type="checkbox"/> Labor signs	<input type="checkbox"/> Signs and symptoms of pregnancy-induced hypertension <input type="checkbox"/> HIV testing <input type="checkbox"/> Childbearing parent's vaccinations <input type="checkbox"/> Risk factors identified by prenatal history <input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange) <input type="checkbox"/> Illicit/recreational drugs <input type="checkbox"/> Fetal movement monitoring <input type="checkbox"/> Kick counts <input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding	<input type="checkbox"/> Preparing to breastfeed <input type="checkbox"/> Safe sleep education <input type="checkbox"/> Importance of keeping postpartum visits <input type="checkbox"/> Postpartum (perinatal) depression <input type="checkbox"/> Family planning (spacing, interconception care, etc.) <input type="checkbox"/> Postpartum family planning/tubal sterilization <input type="checkbox"/> Other, specify:																																					
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110. Were any health education topics discussed at any time between childbearing parent's admission and discharge from the birth hospital? <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K </div> <div style="width: 70%;"> If yes, which topic(s)? </div> </div> <div style="display: grid; grid-template-columns: 1fr 1fr 1fr; gap: 5px;"> <div><input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent</div> <div><input type="checkbox"/> Childbearing parent's vaccinations</div> <div><input type="checkbox"/> Postpartum (perinatal) depression</div> <div><input type="checkbox"/> Where to go for care in case of emergency</div> <div><input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange)</div> <div><input type="checkbox"/> Family planning (spacing, interconception care, etc.)</div> <div><input type="checkbox"/> Current medications</div> <div><input type="checkbox"/> Illicit/recreational drugs</div> <div><input type="checkbox"/> Postpartum family planning/tubal sterilization</div> <div><input type="checkbox"/> Childbearing parent nutrition</div> <div><input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding</div> <div><input type="checkbox"/> Interconception care</div> <div><input type="checkbox"/> Eating disorders such as anorexia or bulimia</div> <div><input type="checkbox"/> Breastfeeding education</div> <div><input type="checkbox"/> Other, specify:</div> <div><input type="checkbox"/> Exercise</div> <div><input type="checkbox"/> Bottle feeding education</div> <div></div> <div><input type="checkbox"/> HIV testing</div> <div><input type="checkbox"/> Safe sleep education</div> <div></div> <div><input type="checkbox"/> Importance of keeping postpartum visits</div> </div>																							
111. Were any infant safety topics discussed at any time between the first prenatal care visit and childbearing parent's discharge from the birth hospital? <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K </div> <div style="width: 70%;"> If yes, which topic(s)? </div> </div> <div style="display: grid; grid-template-columns: 1fr 1fr 1fr; gap: 5px;"> <div><input type="checkbox"/> Bath safety</div> <div><input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent</div> <div><input type="checkbox"/> Abusive Head Trauma/Shaken Baby Syndrome</div> <div><input type="checkbox"/> Use of infant car seat</div> <div><input type="checkbox"/> Infant care</div> <div><input type="checkbox"/> Parenting skills</div> <div><input type="checkbox"/> SUID/Safe sleep education</div> <div><input type="checkbox"/> Where to go for care in case of infant emergency</div> <div><input type="checkbox"/> Infant signs/symptoms that warrant medical attention</div> <div><input type="checkbox"/> Protection from falls</div> <div><input type="checkbox"/> Small object avoidance</div> <div><input type="checkbox"/> Other, specify:</div> <div><input type="checkbox"/> Use of home smoke detector</div> </div>																							
112. Did the childbearing parent experience any stressors during the pregnancy? <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K </div> <div style="width: 70%;"> If yes, which one(s)? </div> </div> <div style="display: grid; grid-template-columns: 1fr 1fr 1fr; gap: 5px;"> <div><input type="checkbox"/> A close family member was very sick</div> <div><input type="checkbox"/> Financial problems</div> <div><input type="checkbox"/> Sexual abuse</div> <div><input type="checkbox"/> Separated or divorced from partner</div> <div><input type="checkbox"/> Involved in a physical fight</div> <div><input type="checkbox"/> Emotional abuse</div> <div><input type="checkbox"/> Lost job</div> <div><input type="checkbox"/> Childbearing parent or partner went to jail</div> <div><input type="checkbox"/> Someone very close to them died</div> <div><input type="checkbox"/> Partner lost job</div> <div><input type="checkbox"/> Someone very close to the childbearing parent had a problem with drinking alcohol or drugs</div> <div><input type="checkbox"/> Afraid of violence in their neighborhood</div> <div><input type="checkbox"/> Childbearing parent and partner argued more than usual</div> <div><input type="checkbox"/> Childbearing parent's partner said they did not want the childbearing parent to be pregnant</div> <div><input type="checkbox"/> Physical abuse</div> </div>																							
113. Was the childbearing parent a victim of intimate partner violence?   * Referral key: <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 10px;"> <div style="width: 40%;"> <table border="0" style="width: 100%;"> <tr> <td style="text-align: right;"><u>CBP as victim:</u></td> <td style="text-align: center;"><u>Y</u>   <u>N</u>   <u>U/K</u></td> <td style="text-align: right;">Referral*</td> </tr> <tr> <td>Preconception</td> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td style="text-align: center;"><input style="width: 50px;" type="text"/></td> </tr> <tr> <td>Pregnancy</td> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td style="text-align: center;"><input style="width: 50px;" type="text"/></td> </tr> <tr> <td>Postpartum</td> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td style="text-align: center;"><input style="width: 50px;" type="text"/></td> </tr> </table> </div> <div style="width: 60%; background-color: #f0f0f0; padding: 5px;"> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">1 - No referral, not needed</td> <td style="width: 50%;">5 - Referral made, services provided</td> </tr> <tr> <td>2 - No referral, already in service</td> <td>9 - U/K</td> </tr> <tr> <td>3 - No referral, needed</td> <td></td> </tr> <tr> <td>4 - Referral made, services not provided</td> <td></td> </tr> </table> </div> </div>				<u>CBP as victim:</u>	<u>Y</u> <u>N</u> <u>U/K</u>	Referral*	Preconception	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input style="width: 50px;" type="text"/>	Pregnancy	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input style="width: 50px;" type="text"/>	Postpartum	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input style="width: 50px;" type="text"/>	1 - No referral, not needed	5 - Referral made, services provided	2 - No referral, already in service	9 - U/K	3 - No referral, needed		4 - Referral made, services not provided	
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114. Was the family referred to any health or human services program during or after the pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If any of these are checked, note whether a referral was made using the following responses:																							
Referral options:   1 - Referral made, services not provided   2 - Referral made, services provided   9 - U/K																							
<table border="0" style="width: 100%;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Case management  <input type="checkbox"/> Infant/child health program  <input type="checkbox"/> Child Protection Services  <input type="checkbox"/> Legal aid  <input type="checkbox"/> Evidence-based home visiting  <input type="checkbox"/> Family planning  <input type="checkbox"/> Mental health service  <input type="checkbox"/> Infant mental health program  <input type="checkbox"/> Genetic evaluation/counseling  <input type="checkbox"/> GED programs  <input type="checkbox"/> Children's Special Health Care Needs </td> <td style="width: 25%; vertical-align: top;"> Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Drug treatment program  <input type="checkbox"/> Smoking cessation program  <input type="checkbox"/> Alcohol cessation program  <input type="checkbox"/> Housing authority  <input type="checkbox"/> Shelters  <input type="checkbox"/> Unemployment assistance  <input type="checkbox"/> Homemaker/home health aide  <input type="checkbox"/> Medicaid  <input type="checkbox"/> WIC  <input type="checkbox"/> TANF  <input type="checkbox"/> SNAP </td> <td style="width: 25%; vertical-align: top;"> Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: </td> </tr> </table>				<input type="checkbox"/> Case management <input type="checkbox"/> Infant/child health program <input type="checkbox"/> Child Protection Services <input type="checkbox"/> Legal aid <input type="checkbox"/> Evidence-based home visiting <input type="checkbox"/> Family planning <input type="checkbox"/> Mental health service <input type="checkbox"/> Infant mental health program <input type="checkbox"/> Genetic evaluation/counseling <input type="checkbox"/> GED programs <input type="checkbox"/> Children's Special Health Care Needs	Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral:	<input type="checkbox"/> Drug treatment program <input type="checkbox"/> Smoking cessation program <input type="checkbox"/> Alcohol cessation program <input type="checkbox"/> Housing authority <input type="checkbox"/> Shelters <input type="checkbox"/> Unemployment assistance <input type="checkbox"/> Homemaker/home health aide <input type="checkbox"/> Medicaid <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> SNAP	Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral: Referral:																
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115. At any time before or during pregnancy or until the infant's death, did the family experience any difficulties in obtaining, communicating, processing, or understanding basic health information and services in order to make informed health decisions? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																							
If this was a fetal death, go to Section A5.																							
116 Apgar:   1 min:   5 min:   10 min: <input type="checkbox"/> U/K																							
117. Were neonatal resuscitation measures required or attempted in delivery room? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, which measure(s)? <div style="display: flex; flex-direction: column; gap: 5px;"> <input type="checkbox"/> Physical stimulation <input type="checkbox"/> Intubation <input type="checkbox"/> Respiratory or cardiac meds for resuscitation <input type="checkbox"/> Oxygen <input type="checkbox"/> Other, specify: </div>		118. Disposition from delivery room, did the infant go to: <div style="display: flex; flex-direction: column; gap: 5px;"> <input type="checkbox"/> Normal newborn nursery <input type="checkbox"/> Rooming in <input type="checkbox"/> Observation/special care nursery (NICU, intensive care or premature nursery) If yes, admitting diagnosis: <input type="checkbox"/> Transferred to another hospital <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K </div>																					



119. Were there morbidities noted during the nursery stay? ☐ N/A ☐ Yes ☐ No ☐ U/K

If yes, what were they?

☐ Perinatal asphyxia

☐ Respiratory distress syndrome

☐ Convulsion

☐ Hypoglycemia (<40)

☐ Neonatal sepsis

☐ Anemia due to fetal hemorrhage

☐ Perinatal STI infection

If yes, specify:

☐ Hemolysis

If yes, due to:

☐ RH ☐ ABO ☐ Other

If other, specify:

☐ Hypothermia

☐ Hypotonia

☐ Temperature instability

☐ Delayed feeding adequacy

☐ Jaundice

☐ Birth injury such as bruising, peripheral nerve damage, cephalohematoma, fractures

If yes, specify:

☐ Other, specify:

If yes, specify highest bilirubin level:

120. Was a urine or meconium toxicology done on the infant? ☐ Yes ☐ No ☐ U/K

If yes, were the results positive or negative? ☐ Positive ☐ Negative ☐ U/K

If positive, for what?

☐ Alcohol, including ethanol and methanol

☐ Amphetamines

☐ Barbiturates

☐ Benzodiazepines

☐ Marijuana/THC

☐ Methadone

☐ Cocaine

☐ Opioids, codeine, oxycodone

☐ Heroin

☐ Phencyclidine (PCP)

☐ Other, specify:

☐ U/K

If the infant never left the hospital following birth, go to Section A5.

121. Date of infant's last discharge from any hospital: \_\_/\_\_/\_\_☐ U/K

122. Total number of days infant hospitalized: ☐ U/K

123. Infant's disposition (after birth, from any hospital):

☐ Home with parents ☐ Other, specify: ☐ U/K

124. Did the infant have a primary care provider? ☐ Yes ☐ No ☐ U/K

125. Were any medications prescribed for the infant at any discharge?

☐ Yes ☐ No ☐ U/K

If yes, specify:

If yes, were parents instructed in medication administration?

☐ Yes ☐ No ☐ U/K

126. Was the infant technologically dependent on discharge from any hospital visit? ☐ Yes ☐ No ☐ U/K

If yes, describe:

127. After the infant came home from the hospital after delivery, did s/he have to go back into the hospital overnight for any reason?

☐ Yes ☐ No ☐ U/K

If yes, how many nights was the infant in the hospital?

Number of nights:

☐ U/K

If yes, how old was the infant when admitted to the hospital for the last time? 

Number of weeks:

☐ U/K

128. Number of outpatient/ambulatory infant encounters:  Of these, how many were well child visits?

List encounters. One line per visit. Maximum 12 encounters. Enter those encounters closest to the death if greater than 12.

Who saw infant: Primary Care Physician; Urgent Care; Emergency Department; Other

Age in months: Enter 0 for infants under 30 days. For reviews of children greater than 12 months old, enter "> 12 m"

Who saw infant

Age in months

Reason for visit

Recommended treatment


A5. FIMR PARENTAL/CAREGIVER INTERVIEW

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

129. Was a home interview conducted? ☐ Yes ☐ No, go to Section B

The following questions focus on the experience of the biological parents.

130. How does the childbearing parent describe the time just before pregnancy?

☐ One of the happiest times of their life

☐ A happy time with a few problems

☐ A moderately hard time

☐ A very hard time

☐ One of the worst times of their life

☐ U/K

131. How does the childbearing parent remember feeling about becoming pregnant?

☐ Wanted to be pregnant sooner

☐ Wanted to be pregnant later

☐ Wanted to be pregnant then

☐ Didn't want to be pregnant then or at any time in the future

☐ U/K

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<p>132. Were any of the following identified as psychosocial or lifestyle problems experienced by the childbearing parent AT ANY TIME in their life, as a child, before or during pregnancy?</p> <p><b>Childbearing parent as a child:</b>  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <div> <input type="checkbox"/> Housing unstable/inadequate/homeless  <input type="checkbox"/> Food insecurity  <input type="checkbox"/> Treated violently  <input type="checkbox"/> Parents or caregiver with substance abuse problem  <input type="checkbox"/> Parents or caregiver problem drinkers  <input type="checkbox"/> Parents or caregiver with mental health problems  <input type="checkbox"/> Parental separation or divorce  <input type="checkbox"/> Incarcerated household member </div>		<p><b>Current (before or during pregnancy):</b>  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <div> <input type="checkbox"/> Disturbed parent/infant relationship  <input type="checkbox"/> Childbearing parent-physical/developmental disability  <input type="checkbox"/> Non-childbearing biological parent-physical/developmental disability  <input type="checkbox"/> Childbearing parent-employment/education needs  <input type="checkbox"/> Non-childbearing biological parent-employment/education needs  <input type="checkbox"/> Inadequate support system  <input type="checkbox"/> Childbearing or non-childbearing biological parent felt “stereotyped” or profiled due to race, gender, class, etc. </div>	
<p>133. How supportive was the non-childbearing biological parent toward the childbearing parent during the pregnancy?  <input type="radio"/> Not involved   <input type="radio"/> Supportive   <input type="radio"/> Unsupportive   <input type="radio"/> U/K</p>		<p>134. During the childbearing parent's recent pregnancy, did they have others who would have helped if a problem had come up? (For example, needed a ride to the clinic or needed to borrow money.)  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, describe who would have helped (significant other, friend, in-laws, other family, etc.):</p>	
<p>135. Did the childbearing parent feel that they were ever treated differently or unfairly in getting services?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, for what reasons?</p> <div> <input type="checkbox"/> Race  <input type="checkbox"/> Culture/ethnic background  <input type="checkbox"/> Citizenship status  <input type="checkbox"/> Marital status </div> <div> <input type="checkbox"/> Type of insurance  <input type="checkbox"/> Ability to pay  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K </div>		<p>136. Was the childbearing parent currently pregnant at time of parental interview?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If no, are they currently using birth control?  <input type="radio"/> Yes, describe type of birth control:  <input type="radio"/> No  <input type="radio"/> Trying to get pregnant  <input type="radio"/> U/K</p>	
<p>137. Does the childbearing parent expect to have any more children?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, how many? _____   <input type="checkbox"/> U/K</p> <p>When: _____   <input type="checkbox"/> U/K</p>			
<p>138. Did the non-childbearing biological parent experience any stressors during the pregnancy?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, which one(s)?</p> <div> <input type="checkbox"/> Work or employment problems  <input type="checkbox"/> Problems with drugs or alcohol  <input type="checkbox"/> Money problems </div> <div> <input type="checkbox"/> Housing problems  <input type="checkbox"/> Emotional problems  <input type="checkbox"/> A death in the family </div> <div> <input type="checkbox"/> Problems with children or other relatives  <input type="checkbox"/> Problems with the law  <input type="checkbox"/> Health problems </div> <div> <input type="checkbox"/> Other, specify: </div>			
<p>The following questions ask about the primary caregiver, who may be the childbearing biological parent or someone else.</p>			
<p>139. Were any of the following identified as psychosocial or lifestyle problems experienced by the caregiver while the infant was still alive?</p> <p><b>Current (after the birth):</b>  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <div> <input type="checkbox"/> Disturbed caregiver/infant relationship  <input type="checkbox"/> Caregiver-physical/developmental disability  <input type="checkbox"/> Caregiver's significant other-physical/developmental disability  <input type="checkbox"/> Caregiver-employment/education needs </div> <div> <input type="checkbox"/> Caregiver's significant other-employment/education needs  <input type="checkbox"/> Inadequate support system  <input type="checkbox"/> Caregiver felt “stereotyped” or profiled due to race, gender, class, etc. </div>			
<p>140. In the months prior to the infant's death, how often did the caregiver feel that daily activities were overwhelming?  <input type="radio"/> Never   <input type="radio"/> Sometimes   <input type="radio"/> Very often  <input type="radio"/> Almost never   <input type="radio"/> Fairly often   <input type="radio"/> U/K</p>		<p>141. In the months prior to the infant's death, how often did the caregiver say that they felt very sad?  <input type="radio"/> Never   <input type="radio"/> Fairly often  <input type="radio"/> Almost never   <input type="radio"/> Very often  <input type="radio"/> Sometimes   <input type="radio"/> U/K</p>	
<p>142. Did the caregiver feel they had family or friends who could help with the infant at home*?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, specify who:</p>		<p>143. Did the caregiver feel that their infant was ever treated differently or unfairly in getting services*?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, for what reasons?</p> <div> <input type="checkbox"/> Race  <input type="checkbox"/> Culture/ethnic background  <input type="checkbox"/> Citizenship status </div> <div> <input type="checkbox"/> Marital status  <input type="checkbox"/> Type of insurance  <input type="checkbox"/> Ability to pay </div> <div> <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K </div>	

144. How satisfied was the caregiver with the caregiver's significant other's contribution(s) toward their or the infant's financial support? <input type="radio"/> Very satisfied <input type="radio"/> Somewhat satisfied <input type="radio"/> Not satisfied <input type="radio"/> U/K	145. According to the caregiver, did they have a crib, portable crib or bassinet for the infant*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often did the infant sleep in it? <input type="radio"/> Always <input type="radio"/> Usually <input type="radio"/> Half the time <input type="radio"/> Occasionally <input type="radio"/> Never <input type="radio"/> U/K If anything other than "always," describe where else the infant slept:		
146. According to the caregiver, was the infant in the same room with someone who was smoking*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K      If yes, number of hours per day, maximum 24:			
If fetal death or the infant never left the hospital following birth, go to Section B			
147. Did the infant ever have an illness for which they weren't seen or treated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what were the barriers? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Lack of money for care</div> <div style="width: 33%;"><input type="checkbox"/> Couldn't get provider to take as a patient</div> <div style="width: 33%;"><input type="checkbox"/> Distrust of health care system</div> <div style="width: 33%;"><input type="checkbox"/> Limitations of health insurance coverage</div> <div style="width: 33%;"><input type="checkbox"/> Multiple providers, not coordinated</div> <div style="width: 33%;"><input type="checkbox"/> Unwilling to obtain care</div> <div style="width: 33%;"><input type="checkbox"/> Lack of transportation</div> <div style="width: 33%;"><input type="checkbox"/> Couldn't get an earlier appointment</div> <div style="width: 33%;"><input type="checkbox"/> Didn't know where to go</div> <div style="width: 33%;"><input type="checkbox"/> No phone</div> <div style="width: 33%;"><input type="checkbox"/> Lack of child care (other children)</div> <div style="width: 33%;"><input type="checkbox"/> Other, specify:</div> <div style="width: 33%;"><input type="checkbox"/> Cultural differences</div> <div style="width: 33%;"><input type="checkbox"/> Lack of family/social support</div> <div style="width: 33%;"><input type="checkbox"/> U/K</div> <div style="width: 33%;"><input type="checkbox"/> Language barriers</div> <div style="width: 33%;"><input type="checkbox"/> Services not available</div> </div>			
<b>B. BIOLOGICAL PARENT INFORMATION</b> <input type="radio"/> 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. <u>Childbearing Biological Parent (CBP) alive:</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <u>Non-Childbearing Biological Parent (Non-CBP) alive:</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
2. Parents' race, check all that apply: <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <input type="radio"/> <input type="radio"/> Yes, specify origin: <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K 4. Parents' age in years at time of child's death: <div style="display: flex; justify-content: space-around;"> <div><u>CBP</u></div> <div><u>Non-CBP</u></div> </div> <div style="display: flex; justify-content: space-around;"> <div>_____</div> <div>_____</div> </div> <div style="text-align: center;"># Years</div> <input type="checkbox"/> <input type="checkbox"/> U/K	5. Parents' employment status: <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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: <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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			
7. Parents speak and understand English? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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 9. Parents on active military duty? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <input type="radio"/> <input type="radio"/> Yes, specify branch: <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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 <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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 </div> <div style="width: 45%;"> <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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 </div> </div>	
11. Parents have substance abuse history? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K
15. Parents have prior child deaths? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <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? <div style="display: flex;"> <div style="width: 50%;"><u>CBP</u></div> <div style="width: 50%;"><u>Non-CBP</u></div> </div> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K	

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. <table><tr><td><u>One</u></td><td><u>Two</u></td><td><u>One</u></td><td><u>Two</u></td><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Self, go to Section D</td><td><input type="radio"/> Foster parent</td><td><input type="radio"/> Other relative</td><td></td><td></td><td></td></tr><tr><td><input type="radio"/> Childbearing parent, go to Section D</td><td><input type="radio"/> Parent's partner</td><td><input type="radio"/> Friend</td><td></td><td></td><td></td></tr><tr><td><input type="radio"/> Non-childbearing biological parent, go to Section D</td><td><input type="radio"/> Grandparent</td><td><input type="radio"/> Institutional staff</td><td></td><td></td><td></td></tr><tr><td><input type="radio"/> Adoptive parent</td><td><input type="radio"/> Sibling</td><td><input type="radio"/> Other, specify:</td><td></td><td></td><td></td></tr><tr><td><input type="radio"/> Stepparent</td><td></td><td><input type="radio"/> U/K</td><td></td><td></td><td></td></tr></table>						<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section D	<input type="radio"/> Foster parent	<input type="radio"/> Other relative				<input type="radio"/> Childbearing parent, go to Section D	<input type="radio"/> Parent's partner	<input type="radio"/> Friend				<input type="radio"/> Non-childbearing biological parent, go to Section D	<input type="radio"/> Grandparent	<input type="radio"/> Institutional staff				<input type="radio"/> Adoptive parent	<input type="radio"/> Sibling	<input type="radio"/> Other, specify:				<input type="radio"/> Stepparent		<input type="radio"/> U/K				2. Caregiver(s) age in years: <table><tr><td><u>One</u></td><td><u>Two</u></td><td># Years</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>U/K</td></tr></table>		<u>One</u>	<u>Two</u>	# Years	<input type="checkbox"/>	<input type="checkbox"/>	U/K
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<u>One</u>	<u>Two</u>	# Years																																															
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3. Caregiver(s) sex: <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Male</td><td><input type="radio"/> Female</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table>		<u>One</u>	<u>Two</u>	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> U/K																																											
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4. Caregiver(s) race, check all that apply: <table><tr><td><u>One</u></td><td><u>Two</u></td><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="checkbox"/> Alaska Native, Tribe:</td><td><input type="checkbox"/> Pacific Islander, specify:</td><td></td><td></td></tr><tr><td><input type="checkbox"/> American Indian, Tribe:</td><td></td><td></td><td></td></tr><tr><td><input type="checkbox"/> Asian, specify:</td><td><input type="checkbox"/> White</td><td></td><td></td></tr><tr><td><input type="checkbox"/> Black</td><td><input type="checkbox"/> U/K</td><td></td><td></td></tr><tr><td><input type="checkbox"/> Native Hawaiian</td><td></td><td></td><td></td></tr></table>			<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="checkbox"/> Alaska Native, Tribe:	<input type="checkbox"/> Pacific Islander, specify:			<input type="checkbox"/> American Indian, Tribe:				<input type="checkbox"/> Asian, specify:	<input type="checkbox"/> White			<input type="checkbox"/> Black	<input type="checkbox"/> U/K			<input type="checkbox"/> Native Hawaiian				5. Caregiver(s) Hispanic or Latino/a origin? <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Yes</td><td><input type="radio"/> No</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table> If yes, specify origin:		<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		6. Caregiver(s) employment status: <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Employed</td><td><input type="radio"/> Unemployed</td></tr><tr><td><input type="radio"/> On disability</td><td><input type="radio"/> Stay-at-home</td></tr><tr><td><input type="radio"/> Retired</td><td><input type="radio"/> U/K</td></tr></table>		<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> U/K					
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7. Caregiver(s) education: <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> &lt; High school</td><td><input type="radio"/> High school/GED</td></tr><tr><td><input type="radio"/> College</td><td><input type="radio"/> Post graduate</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table>		<u>One</u>	<u>Two</u>	<input type="radio"/> < High school	<input type="radio"/> High school/GED	<input type="radio"/> College	<input type="radio"/> Post graduate	<input type="radio"/> U/K		8. Do caregiver(s) speak and understand English? <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Yes</td><td><input type="radio"/> No</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table> If no, language spoken:		<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		9. Caregiver(s) first generation immigrant? <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Yes, country of origin:</td><td><input type="radio"/> No</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table>		<u>One</u>	<u>Two</u>	<input type="radio"/> Yes, country of origin:	<input type="radio"/> No	<input type="radio"/> U/K		10. Caregiver(s) on active military duty? <table><tr><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Yes, specify branch:</td><td><input type="radio"/> No</td></tr><tr><td><input type="radio"/> U/K</td><td></td></tr></table>		<u>One</u>	<u>Two</u>	<input type="radio"/> Yes, specify branch:	<input type="radio"/> No	<input type="radio"/> U/K																	
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11. Caregiver(s) receive social services in the past twelve months? <table><tr><td><u>One</u></td><td><u>Two</u></td><td rowspan="4">If yes, check all services that apply:</td><td><u>One</u></td><td><u>Two</u></td><td><u>One</u></td><td><u>Two</u></td></tr><tr><td><input type="radio"/> Yes</td><td><input type="radio"/> No</td><td><input type="checkbox"/> WIC</td><td><input type="checkbox"/> Home visiting</td><td><input type="checkbox"/> Food stamps/SNAP/EBT</td><td><input type="checkbox"/> Section 8/housing</td></tr><tr><td><input type="radio"/> U/K</td><td></td><td></td><td>specify:</td><td><input type="checkbox"/> Soc Sec Disability (SSI/SSDI)</td><td><input type="checkbox"/> Other, specify:</td></tr><tr><td></td><td></td><td><input type="checkbox"/> TANF</td><td><input type="checkbox"/> Medicaid</td><td><input type="checkbox"/> U/K</td><td></td></tr></table>								<u>One</u>	<u>Two</u>	If yes, check all services that apply:	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="checkbox"/> WIC	<input type="checkbox"/> Home visiting	<input type="checkbox"/> Food stamps/SNAP/EBT	<input type="checkbox"/> Section 8/housing	<input type="radio"/> U/K			specify:	<input type="checkbox"/> Soc Sec Disability (SSI/SSDI)	<input type="checkbox"/> Other, specify:			<input type="checkbox"/> TANF	<input type="checkbox"/> Medicaid	<input type="checkbox"/> U/K																		
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D. SUPERVISOR INFORMATION																																																	
Answer this section only if the child ever left the hospital following birth																																																	
1. Did child have supervision at time of incident leading to death? <input type="radio"/> Yes, answer D2-16 <input type="radio"/> No, not needed given developmental age or circumstances, go to Sec. E <input type="radio"/> No, but needed, answer D3-16 <input type="radio"/> Unable to determine, try to answer D3-16				2. How long before incident did supervisor last see child? Select one: <input type="radio"/> Child in sight of supervisor <input type="radio"/> Minutes _____ <input type="radio"/> Hours _____ <input type="radio"/> Days _____ <input type="radio"/> U/K																																													
3. Is supervisor listed in a previous section? <input type="radio"/> Yes, childbearing parent, go to D15 <input type="radio"/> Yes, non-childbearing biological parent, go to D15 <input type="radio"/> Yes, caregiver one, go to D15 <input type="radio"/> Yes, caregiver two, go to D15 <input type="radio"/> No		4. Primary person responsible for supervision at the time of incident? Select only one: <table><tr><td><input type="radio"/> Adoptive parent</td><td><input type="radio"/> Sibling</td><td><input type="radio"/> Institutional staff, go to D15</td></tr><tr><td><input type="radio"/> Stepparent</td><td><input type="radio"/> Other relative</td><td><input type="radio"/> Babysitter</td></tr><tr><td><input type="radio"/> Foster parent</td><td><input type="radio"/> Friend</td><td><input type="radio"/> Licensed child care worker</td></tr><tr><td><input type="radio"/> Parent's partner</td><td><input type="radio"/> Acquaintance</td><td><input type="radio"/> Other, specify:</td></tr><tr><td><input type="radio"/> Grandparent</td><td><input type="radio"/> Hospital staff, go to D15</td><td><input type="radio"/> U/K</td></tr></table>						<input type="radio"/> Adoptive parent	<input type="radio"/> Sibling	<input type="radio"/> Institutional staff, go to D15	<input type="radio"/> Stepparent	<input type="radio"/> Other relative	<input type="radio"/> Babysitter	<input type="radio"/> Foster parent	<input type="radio"/> Friend	<input type="radio"/> Licensed child care worker	<input type="radio"/> Parent's partner	<input type="radio"/> Acquaintance	<input type="radio"/> Other, specify:	<input type="radio"/> Grandparent	<input type="radio"/> Hospital staff, go to D15	<input type="radio"/> U/K																											
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<input type="radio"/> Parent's partner	<input type="radio"/> Acquaintance	<input type="radio"/> Other, specify:																																															
<input type="radio"/> Grandparent	<input type="radio"/> Hospital staff, go to D15	<input type="radio"/> U/K																																															

5. Supervisor's age in years: <div></div> <div><input type="checkbox"/> U/K</div>		6. Supervisor's sex: <div><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</div>		7. Supervisor speaks and understands English? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div> <div>If no, language spoken:</div>		8. Supervisor on active military duty? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div> <div>If yes, specify branch:</div>	
9. Supervisor has substance abuse history? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div>		10. Supervisor has history of child maltreatment? <div><div>As Victim</div><div><input type="radio"/></div><div><input type="radio"/> Yes</div><div><input type="radio"/></div><div><input type="radio"/> No</div><div><input type="radio"/></div><div><input type="radio"/> U/K</div></div> <div>As Perpetrator</div>		11. Supervisor has disability or chronic illness? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div>		12. Supervisor has prior child deaths? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div>	
13. Supervisor has history of intimate partner violence? <div><input type="checkbox"/> Yes, as victim</div> <div><input type="checkbox"/> Yes, as perpetrator</div> <div><input type="checkbox"/> No</div> <div><input type="checkbox"/> U/K</div>		14. Supervisor has delinquent or criminal history? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div>		15. At the time of the incident, was the supervisor asleep? <div><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div> <div>If yes, select the most appropriate description of the supervisor's sleeping period at incident:</div> <div><input type="radio"/> Night time sleep</div> <div><input type="radio"/> Day time nap, describe:</div> <div><input type="radio"/> Day time sleep (for example, supervisor is night shift worker), describe:</div> <div><input type="radio"/> Other, describe:</div>		16. At time of incident was supervisor impaired? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <div>If yes, check all that apply:</div> <div><input type="checkbox"/> Drug impaired, specify:</div> <div><input type="checkbox"/> Alcohol impaired</div> <div><input type="checkbox"/> Distracted</div> <div><input type="checkbox"/> Absent</div> <div><input type="checkbox"/> Impaired by illness, specify:</div> <div><input type="checkbox"/> Impaired by disability, specify:</div> <div><input type="checkbox"/> Other, specify:</div>	
E. INCIDENT INFORMATION <div>Answer only E7 if the child never left the hospital following birth</div>							
1. Was the date of the incident the same as the date of death? <div><input type="radio"/> Yes, same as date of death</div> <div><input type="radio"/> No, different than date of death. Enter date of incident: <div></div><div>mm / dd / yyyy</div></div> <div><input type="radio"/> U/K</div>				2. Approximate time of day that incident occurred? <div><div><input type="radio"/> AM</div><div><input type="radio"/> PM</div><div><input type="radio"/> U/K</div></div> <div>Hour, specify 1-12: <div></div></div>			
3. Place of incident, check all that apply: <div><div><input type="checkbox"/> Child's home</div><div><input type="checkbox"/> Licensed child care center</div><div><input type="checkbox"/> Military installation</div><div><input type="checkbox"/> State or county park, other recreation area</div><div><input type="checkbox"/> Relative's home</div><div><input type="checkbox"/> Licensed child care home</div><div><input type="checkbox"/> Jail/detention facility</div><div><input type="checkbox"/> Hospital</div><div><input type="checkbox"/> Friend's home</div><div><input type="checkbox"/> Unlicensed child care home</div><div><input type="checkbox"/> Sidewalk</div><div><input type="checkbox"/> Other, specify:</div><div><input type="checkbox"/> Licensed foster care home</div><div><input type="checkbox"/> Farm/ranch</div><div><input type="checkbox"/> Roadway</div><div><input type="checkbox"/> U/K</div><div><input type="checkbox"/> Relative foster care home</div><div><input type="checkbox"/> School</div><div><input type="checkbox"/> Driveway</div><div></div><div><input type="checkbox"/> Licensed group home</div><div><input type="checkbox"/> Indian reservation/trust lands</div><div><input type="checkbox"/> Other parking area</div></div>							



F. INVESTIGATION INFORMATION			A + symbol means that the question is skipped for fetal deaths.																																						
1. Was a death investigation conducted*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <div style="float: right;">If yes, check all that apply:</div> <div style="clear: both;"></div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Medical examiner  <input type="checkbox"/> Coroner             </div> <div> <input type="checkbox"/> ME investigator  <input type="checkbox"/> Coroner investigator             </div> <div> <input type="checkbox"/> Law enforcement  <input type="checkbox"/> Fire investigator             </div> <div> <input type="checkbox"/> EMS  <input type="checkbox"/> Child Protective Services             </div> <div> <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K             </div> </div> <div style="margin-top: 5px;">             If yes, which of the following death investigation components were completed?             <table style="width: 100%; border: none;"> <tr> <th style="text-align: left; padding: 2px;">Yes</th> <th style="text-align: left; padding: 2px;">No</th> <th style="text-align: left; padding: 2px;">U/K</th> <th style="padding: 2px;"></th> <th style="text-align: left; padding: 2px;">If yes, shared with review team?</th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Narrative description of circumstances</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene photos</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation with doll</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation without doll</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Witness interviews</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> </table> </div> <div style="margin-top: 5px;">             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           </div>						Yes	No	U/K		If yes, shared with review team?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/> Yes <input type="radio"/> No	
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/> Yes <input type="radio"/> No																																					
2. What additional information would the team like to have known about the death scene investigation*?																																									
3. Death referred to*: <input type="radio"/> Medical examiner <input type="radio"/> Not referred <input type="radio"/> Coroner <input type="radio"/> U/K			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:																																						
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 <input type="radio"/> Pediatric pathologist <input type="radio"/> Other physician <input type="radio"/> General pathologist <input type="radio"/> Other, specify: <input type="radio"/> U/K <div style="float: right;">             If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K              If yes, specify specialist: _____              If no, why not (e.g. parent or caregiver objected)? _____           </div>																																									
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. <table style="width: 100%; border: none;"> <tr> <th style="text-align: left; padding: 2px;">Yes</th> <th style="text-align: left; padding: 2px;">No</th> <th style="text-align: left; padding: 2px;">U/K</th> </tr> <tr> <td colspan="3"><b>Imaging:</b></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> X-ray - single</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> X-ray - multiple views</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> X-ray - complete skeletal series</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):</td> </tr> </table>			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):	7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10. <table style="width: 100%; border: none;"> <tr> <th style="text-align: left; padding: 2px;">Yes</th> <th style="text-align: left; padding: 2px;">No</th> <th style="text-align: left; padding: 2px;">U/K</th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Cultures for infectious disease</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Microscopic/histologic exam</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Postmortem metabolic screen</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Vitreous testing</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Genetic testing</td> </tr> </table>			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
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Genetic testing																																							
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																																									
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: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Review of the newborn metabolic screen results?</td> <td><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> <td><input type="radio"/> Not performed</td> </tr> <tr> <td>Review of neonatal CCHD screen results?</td> <td><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> <td><input type="radio"/> Not performed</td> </tr> </table>						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																														
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10. Describe any abnormalities or other significant findings noted in the autopsy*:																																									
11. What additional information would the team like to have known about the autopsy*?		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:																																							
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																																									
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			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? Check all that apply: <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																																						
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			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		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																																				



G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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:

☐ U/K

2. Enter the following information exactly as written on the death certificate:

☐ 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.

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate:

☐ U/K

4. If injury, describe how injury occurred exactly as written on the death certificate:

☐ U/K

5. Official manner of death from the death certificate:

☐ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Undetermined

☐ Pending

☐ U/K

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 I2

☐ Other cause, go to H9

☐ U/K, go to I2

☐ 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 I2

☐ U/K, go to I2

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

☐ None

☐ Car

☐ Van

☐ Sport utility vehicle

☐ Truck

☐ Semi/tractor trailer

☐ RV/bus/school bus

☐ Motorcycle

☐ Tractor/farm vehicle

☐ All terrain vehicle

☐ Snowmobile

☐ Bicycle

☐ Train/subway/trolley

☐ Other, specify:

☐ U/K

Autonomous?

N/A

Yes

No

U/K

Child's vehicle

Other vehicle

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

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<p>c. Did any of the following contribute to the incident? Check all that apply:</p> <div> <input type="checkbox"/> None listed below <input type="checkbox"/> Poor sight line </div> <div> <input type="checkbox"/> Speeding over limit <input type="checkbox"/> Road hazard </div> <div> <input type="checkbox"/> Unsafe speed for conditions <input type="checkbox"/> Car changing lanes </div> <div> <input type="checkbox"/> Recklessness <input type="checkbox"/> Driver inexperience </div> <div> <input type="checkbox"/> Carelessness <input type="checkbox"/> Electronic use e.g., cell phone, smart watch,in-car navigation </div> <div> <input type="checkbox"/> Racing, not authorized <input type="checkbox"/> Driver distraction </div> <div> <input type="checkbox"/> Drug use <input type="checkbox"/> Ran stop sign or red light </div> <div> <input type="checkbox"/> Alcohol use <input type="checkbox"/> Other driver error, specify: </div> <div> <input type="checkbox"/> Vehicle ran over child <input type="checkbox"/> Other, specify: </div> <div> <input type="checkbox"/> Vehicle flipped over <input type="checkbox"/> U/K </div> <div> <input type="checkbox"/> Poor weather <input type="checkbox"/> Poor visibility </div>
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<p>f. Incident type:</p> <div> <input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle </div> <div> <input type="radio"/> Child in/on a vehicle, struck by the other vehicle </div> <div> <input type="radio"/> Child in/on a vehicle that struck the other vehicle </div> <div> <input type="radio"/> Child in/on a vehicle that struck person/object/ran off the road </div> <div> <input type="radio"/> Other event, specify: </div> <div> <input type="radio"/> U/K </div>	<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> <div> <input type="radio"/> Child was responsible as driver of vehicle, including single vehicle incidents </div> <div> <input type="radio"/> Driver of child's vehicle was responsible, including single vehicle incidents </div> <div> <input type="radio"/> Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle </div> <div> <input type="radio"/> Multiple drivers were responsible, go to j </div> <div> <input type="radio"/> Unable to determine driver responsible, go to j </div> <div> <input type="radio"/> Other, specify: </div> <div> <input type="radio"/> U/K </div>
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<p>h. Age and license type of driver responsible for incident, check all that apply:</p> <div> <div>Age of Driver (if not child)</div> <div>License type/violation:</div> <div> <input type="radio"/> &lt;16 years <input type="checkbox"/> Has no license </div> <div> <input type="radio"/> 16 to 18 years old <input type="checkbox"/> Has a learner's permit </div> <div> <input type="radio"/> 19 to 21 years old <input type="checkbox"/> Has a graduated license </div> <div> <input type="radio"/> 22 to 29 years old <input type="checkbox"/> Has a full license </div> <div> <input type="radio"/> 30 to 65 years old <input type="checkbox"/> Has a full license that has been restricted </div> <div> <input type="radio"/> &gt;65 years old <input type="checkbox"/> Has a suspended license </div> <div> <input type="radio"/> U/K <input type="checkbox"/> Was violating graduated licensing rules </div> <div> <input type="checkbox"/> Other, specify: </div> <div> <input type="checkbox"/> U/K </div> </div>
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<p><b>H2. FIRE, BURN, OR ELECTROCUTION</b></p>					
<p>a. Ignition, heat or electrocution source:</p> <div> <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning </div> <div> <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Hot bath water </div> <div> <input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Other, specify: </div> <div> <input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> U/K </div> <div> <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring </div>			<p>b. Type of incident:</p> <div> <input type="radio"/> Fire, go to c </div> <div> <input type="radio"/> Scald, go to I2 </div> <div> <input type="radio"/> Electrocution, go to o </div> <div> <input type="radio"/> U/K, go to I2 </div>		<p>c. Type of building on fire:</p> <div> <input type="radio"/> N/A <input type="radio"/> Trailer/mobile home </div> <div> <input type="radio"/> Single home </div> <div> <input type="radio"/> Row home/townhouse <input type="radio"/> Other, specify: </div> <div> <input type="radio"/> Multi-unit (duplex, apartment, condo) <input type="radio"/> U/K </div>
<p>d. Fire started by a person?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>If yes, person's age:</p> <p>If yes, did the person have a history of starting fires?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>If yes, suspected arson?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>e. Did any factors delay fire department arrival?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>If yes, specify:</p>		<p>f. Were barriers preventing safe exit?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>If yes, check all that apply:</p> <div> <input type="checkbox"/> Locked/blocked door <input type="checkbox"/> Smoke/fire </div> <div> <input type="checkbox"/> Window security bars <input type="checkbox"/> Household items/hoarding </div> <div> <input type="checkbox"/> Locked/blocked window <input type="checkbox"/> Other, specify: </div> <div> <input type="checkbox"/> Blocked stairway <input type="checkbox"/> U/K </div> <div> <input type="checkbox"/> Trapped above first floor </div>	
<p>g. Was the child found in the same location as where the fire started?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>h. Was building a rental property?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>i. Were building/rental codes violated?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>If yes, describe in narrative.</p>	
<p>j. Were proper working fire extinguishers present?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>k. Was fire sprinkler system present?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>l. Was fire sprinkler system required?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>	
<p>m. Were smoke alarms present?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div> <p>Were they functioning properly?</p> <div> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </div>		<p>n. Did the child or family (check all that apply):</p> <div> <input type="checkbox"/> None listed below <input type="checkbox"/> Have two or more possible exits from the location as where the child was found <input type="checkbox"/> U/K </div> <div> <input type="checkbox"/> Have a fire escape plan </div> <div> <input type="checkbox"/> Practice a home fire drill <input type="checkbox"/> Attempt to put out the fire </div>			

o. For electrocution, what cause: <div><div><input type="radio"/> Lightning/electrical storm</div><div><input type="radio"/> Faulty wiring</div></div> <div><div><input type="radio"/> Contact with power line</div><div><input type="radio"/> Wire/product in water</div></div> <div><div><input type="radio"/> Child playing with outlet</div><div><input type="radio"/> Other, specify:</div></div> <div><div><input type="radio"/> U/K</div></div>					
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H5. BODILY FORCE OR WEAPON				
a. Was the death a result of a weapon? <input type="radio"/> Yes, go to b <input type="radio"/> No, death due to bodily force, go to l <input type="radio"/> U/K, go to b	b. Type of weapon: <input type="radio"/> Firearm, go to c <input type="radio"/> Knife or sharp instrument, go to l <input type="radio"/> Rope, go to l <input type="radio"/> Other, specify and go to l <input type="radio"/> U/K, go to l	c. For firearms, type: <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> Rifle, specify: <input type="radio"/> 3D gun <input type="radio"/> Other, specify: <input type="radio"/> U/K	d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Was firearm kept loaded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If no, was the ammunition stored locked? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
f. Was the firearm kept locked? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	i. Was the person handling the firearm the owner? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K j. Owner of fatal firearm: <input type="radio"/> Caregiver <input type="radio"/> Other family member <input type="radio"/> Child's significant other <input type="radio"/> Friend/acquaintance <input type="radio"/> Stranger <input type="radio"/> Other, specify: <input type="radio"/> U/K		l. Use of weapon at time, check all that apply: <div> <input type="checkbox"/> Self injury             <input type="checkbox"/> Hunting           </div> <div> <input type="checkbox"/> Commission of crime             <input type="checkbox"/> Target shooting           </div> <div> <input type="checkbox"/> Drug dealing/trading             <input type="checkbox"/> Playing with weapon           </div> <div> <input type="checkbox"/> Drive-by shooting             <input type="checkbox"/> Showing gun to others           </div> <div> <input type="checkbox"/> Random violence             <input type="checkbox"/> Russian roulette           </div> <div> <input type="checkbox"/> Child abuse             <input type="checkbox"/> Gang-related activity           </div> <div> <input type="checkbox"/> Child was a bystander             <input type="checkbox"/> Self-defense           </div> <div> <input type="checkbox"/> Argument             <input type="checkbox"/> Cleaning weapon           </div> <div> <input type="checkbox"/> Jealousy             <input type="checkbox"/> Loading weapon           </div> <div> <input type="checkbox"/> Intimate partner violence             <input type="checkbox"/> Other, specify:           </div> <div> <input type="checkbox"/> Hate crime             <input type="checkbox"/> U/K           </div> <div> <input type="checkbox"/> Bullying             <input type="checkbox"/> U/K           </div>	
g. Did the shooter of the firearm have permission to use the firearm at the time of incident? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
h. Did the caregiver or supervisor know a firearm was present at the time of incident? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	k. Was the firearm stolen? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
m. Type of bodily force used. Check all that apply: <div> <input type="checkbox"/> Beat, kick or punch             <input type="checkbox"/> Bite             <input type="checkbox"/> Throw             <input type="checkbox"/> Other, specify:           </div> <div> <input type="checkbox"/> Drop             <input type="checkbox"/> Shake             <input type="checkbox"/> Drown           </div> <div> <input type="checkbox"/> Push             <input type="checkbox"/> Strangle/choke             <input type="checkbox"/> Burn             <input type="checkbox"/> U/K           </div>				
H6. FALL OR CRUSH				
a. Type: <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to g	b. Height of fall: _____ feet _____ inches <input type="checkbox"/> U/K	c. Child fell from: <div> <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:           </div> <div> <input type="radio"/> Screen             <input type="radio"/> Man-made elevation             <input type="radio"/> Furniture             <input type="radio"/> Bridge             <input type="radio"/> Other, specify:           </div> <div> <input type="radio"/> No screen             <input type="radio"/> Playground equipment             <input type="radio"/> Bed             <input type="radio"/> Overpass           </div> <div> <input type="radio"/> U/K if screen             <input type="radio"/> Tree             <input type="radio"/> Roof             <input type="radio"/> Balcony             <input type="radio"/> U/K           </div>		
d. Surface child fell onto: <input type="radio"/> Cement/concrete <input type="radio"/> Linoleum/vinyl <input type="radio"/> Grass <input type="radio"/> Marble/tile <input type="radio"/> Gravel <input type="radio"/> Other, specify: <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> U/K		e. Barrier in place, check all that apply:. <div> <input type="checkbox"/> None             <input type="checkbox"/> Stairway           </div> <div> <input type="checkbox"/> Screen             <input type="checkbox"/> Gate           </div> <div> <input type="checkbox"/> Other window guard             <input type="checkbox"/> Other, specify:           </div> <div> <input type="checkbox"/> Fence             <input type="checkbox"/> U/K           </div> <div> <input type="checkbox"/> Railing           </div>		g. For crush, did child: <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K
		h. For crush, object causing crush: <div> <input type="radio"/> Appliance             <input type="radio"/> Boulders/rocks           </div> <div> <input type="radio"/> Television             <input type="radio"/> Dirt/sand           </div> <div> <input type="radio"/> Furniture             <input type="radio"/> Person, go to H5l           </div> <div> <input type="radio"/> Walls             <input type="radio"/> Commercial           </div> <div> <input type="radio"/> Playground equipment             <input type="radio"/> Farm equipment           </div> <div> <input type="radio"/> Animal             <input type="radio"/> Other, specify:           </div> <div> <input type="radio"/> Tree branch             <input type="radio"/> U/K           </div>		

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:

Source of Substance

1 = Bought from dealer or stranger  
(Prescription or illicit only)

2 = Bought from friend or relative

3 = From friend or relative for free

4 = Took from friend or relative without asking

5 = Own prescription (Prescription only)

6 = Bought from store/pharmacy  
(OTC or other substances only)

7 = Other

9 = U/K

Stored in locked cabinet?

Yes

No

U/K

How substance was taken

1 = In utero

2 = Orally

3 = Nasally

4 = Intravenously

5 = Through skin

9 = U/K

Prescription drug

☐ Antidepressant/antianxiety

☐ Anticonvulsant

☐ Antipsychotic

☐ Benzodiazepines

☐ Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)

☐ Non-opioid pain medication

☐ Opioid pain medication (including fentanyl)

☐ Stimulants

☐ Other Rx, specify:

Was it child's prescription?

☐ Yes

☐ No

☐ U/K

Source

Stored

Taken

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Over-the-counter drug

☐ Antihistamine

☐ Cold medicine

☐ Pain medication

☐ Other OTC, specify:

Source

Stored

Taken

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Illicit drugs

☐ Cocaine

☐ Heroin

☐ Illicitly manufactured fentanyl/fentanyl analogs

☐ Marijuana/THC

☐ Methamphetamine

☐ Other, specify:

Source

Stored

Taken

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Y

N

U

Other substances

☐ Alcohol

☐ Battery

☐ Carbon monoxide

☐ Other fume/gas/vapor

☐ Other, specify:

Source

Stored

Taken

Y

N

U

Y

N

U

Y

N

U

Y

N

U

b. Was the incident the result of?

☐ Accidental overdose/acute intoxication

☐ Medical treatment mishap

☐ Deliberate poisoning

☐ Other, specify:

☐ U/K

c. Did the child have a prescription for a controlled substance within the previous 24 months?

☐ Yes

☐ No

☐ U/K

d. Did child have a non-fatal overdose within the previous 12 months?

☐ Yes

☐ No

☐ U/K

e. Was Poison Control contacted?

☐ Yes

☐ No

☐ U/K

f. For CO poisoning, was a CO alarm present?

☐ Yes

☐ No

☐ U/K

H8. MEDICAL CONDITION

This section is skipped for fetal deaths<sup>+</sup>

a. How long did the child have the medical condition?

☐ In utero

☐ Since birth

☐ < 1 day

☐ 1-6 days

☐ 7-30 Days

☐ 1-11 months

☐ >= 1 year

☐ U/K

b. Was the death expected as a result of the medical condition?

☐ N/A, not previously diagnosed

☐ Yes

☐ No

☐ U/K

☐ But at a later date

c. Was child receiving health care for the medical condition?

☐ Yes

☐ No

☐ U/K

If yes, within 48 hours of the death?

☐ Yes

☐ No

☐ U/K

If yes, was the care plan appropriate for the medical condition?

☐ N/A

☐ Yes

☐ No

☐ U/K

If no, specify:

d. Did the family experience barriers that prohibited following the care plan?

☐ N/A

☐ Yes

☐ No

☐ U/K

If yes, what treatment components were not completed?

Check all that apply.

☐ Appointments

☐ Medications, specify:

☐ Medical equipment use, specify:

☐ Therapies, specify:

☐ Other, specify:

☐ U/K

e. In the week prior to the death, did the child experience any changes to medical care?

☐ Yes, describe:

☐ No

☐ U/K

f. Was the medical condition associated with an outbreak?

☐ Yes, specify:

☐ No

☐ U/K

If yes, was the child vaccinated?

☐ Yes

☐ No

☐ U/K

g. Was the death potentially caused by a medical error?

☐ Yes

☐ No

☐ 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?

☐ Yes

☐ No

☐ U/K

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

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I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS			
I2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:			
WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT*? <input type="radio"/> Yes, go to I2a <input type="radio"/> No, go to I2t <input type="radio"/> U/K, go to I2a			
a. Incident sleep place: <div><div><input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box</div><div><input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat</div><div><input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K</div><div><div>If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K</div><div>If car seat, was car seat secured in seat of car? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</div></div></div>			
b. Child put to sleep: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	c. Child found: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	e. Usual sleep position: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	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
d. Usual sleep place: <div><div><input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box</div><div><input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat</div><div><input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K</div><div><div>If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K</div></div></div>			
g. Child in a new or different environment than usual? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe why:		h. Child last placed to sleep with a pacifier? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
		i. Child wrapped or swaddled in blanket when last placed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:	
j. Child overheated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Check all that apply: <input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing		k. Child exposed to second hand smoke? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally	
l. Child's face when found: <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	m. Child's neck when found: <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> Turned <input type="radio"/> U/K	n. Child's airway when found (includes nose, mouth, neck and/or chest): <input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K	<div>If fully or partially obstructed, what was obstructed? <input type="checkbox"/> Nose <input type="checkbox"/> Chest compressed <input type="checkbox"/> Mouth <input type="checkbox"/> U/K <input type="checkbox"/> Neck compressed</div> <div>If fully or partially obstructed, describe obstruction in detail:</div>



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

Objects:	If <b>present</b> , describe position of object:								If <b>present</b> , did object obstruct airway?			
	Present?		U/K	On top	Under	Next	Tangled	U/K	Yes	No	UK	
	Yes	No		of child	child	to child	around child					
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"/>	→ If adult(s) obstructed airway, describe relationship of adult to child (for example, childbearing parent):
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"/>	

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? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> Breast <input type="radio"/> U/K	r. Child sleeping in the same room as caregiver/supervisor at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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s. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	If yes, reasons stated for sleeping on same surface, check all that apply: <input type="checkbox"/> To feed <input type="checkbox"/> To soothe <input type="checkbox"/> Usual sleep pattern <input type="checkbox"/> No infant bed available <input type="checkbox"/> Home/living space overcrowded <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K	If yes, check all that apply: <input type="checkbox"/> With adult(s): # _____ <input type="checkbox"/> # U/K Adult obese: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> With other children: # _____ <input type="checkbox"/> # U/K Children's ages: _____ <input type="checkbox"/> With animal(s): # _____ <input type="checkbox"/> # U/K Type(s) of animal: _____ <input type="checkbox"/> U/K
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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.

I3. 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 Safety Administration <input type="radio"/> Consumer Product Safety Commission <input type="radio"/> Food and Drug Administration <input type="radio"/> U/K

I4. 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:

☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K  
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft  
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I5. 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:  <div><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</div> <div><input type="checkbox"/> 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"/> Other hazard, specify:</div>		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"/> Childbearing parent substance use during pregnancy <input type="radio"/> Other hazard, specify:	
h. Was poverty a factor? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, explain in Narrative				
I7. LIFE STRESSORS Please indicate all stressors that were present for this child and family around the time of death.				
a. Life stressors - Social/economic <div><input type="checkbox"/> None listed below <input type="checkbox"/> Racism <input type="checkbox"/> Discrimination <input type="checkbox"/> Poverty</div> <div><input type="checkbox"/> Neighborhood discord <input type="checkbox"/> Job problems <input type="checkbox"/> Money problems <input type="checkbox"/> Food insecurity</div> <div><input type="checkbox"/> No phone <input type="checkbox"/> Housing instability <input type="checkbox"/> Witnessed violence <input type="checkbox"/> Tobacco exposure</div> <div><input type="checkbox"/> Lack of transportation <input type="checkbox"/> Cultural differences <input type="checkbox"/> Language barriers</div> <div><input type="checkbox"/> Lack of child care <input type="checkbox"/> Pregnancy <input type="checkbox"/> Pregnancy scare</div>				
b. Life stressors - Medical <div><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</div> <div><input type="checkbox"/> Caregiver unskilled in providing care <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Services not available</div> <div><input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Limitations of health insurance <input type="checkbox"/> Provider bias</div> <div><input type="checkbox"/> Felt dismissed by provider <input type="checkbox"/> Lack of provider-family compatibility</div>				
c. Life Stressors- Relationships <div><input type="checkbox"/> None listed below <input type="checkbox"/> Family discord <input type="checkbox"/> Argument w/ parents/caregivers <input type="checkbox"/> Parents' divorce/separation</div> <div><input type="checkbox"/> Parents' incarceration <input type="checkbox"/> Breakup <input type="checkbox"/> Argument with significant other <input type="checkbox"/> Social discord</div> <div><input type="checkbox"/> Argument with friends <input type="checkbox"/> Isolation <input type="checkbox"/> Bullying as victim <input type="checkbox"/> Bullying as perpetrator</div> <div><input type="checkbox"/> Cyberbullying as victim <input type="checkbox"/> Cyberbullying as a perpetrator <input type="checkbox"/> Peer violence as a victim <input type="checkbox"/> Peer violence as a perpetrator</div> <div><input type="checkbox"/> Stress due to gender identity <input type="checkbox"/> Stress due to sexual orientation</div>				
h. Life stressors - Describe any other life stressors:				
I8. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)				
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: <div><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</div> <div><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</div>				
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? <span style="float:right"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K         </span> If eligible, did they receive their first dose? <span style="float:right"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K   If yes, approx. number of weeks before death: ____         </span> If eligible and received their first dose, which option best represents their vaccination status? <span style="float:right"> <input type="radio"/> Partially vaccinated   <input type="radio"/> Fully vaccinated   <input type="radio"/> U/K         </span>																																																	
f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? <span style="float:right"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K         </span> If yes, when did they receive their first dose? <span style="float:right"> <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         </span> If yes, which option best represents their vaccination status? <span style="float:right"> <input type="radio"/> Partially vaccinated   <input type="radio"/> Fully vaccinated   <input type="radio"/> U/K         </span>																																																	
g. Select the one option that best describes the impact of COVID-19 on this child's death: <input type="radio"/> COVID-19 was the immediate or underlying cause of death <input type="radio"/> COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19 <input type="radio"/> COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death <input type="radio"/> The childbearing parent contracted COVID-19, specify: <div style="display: flex; justify-content: space-around;"> <span><input type="radio"/> Before pregnancy</span> <span><input type="radio"/> 3rd trimester</span> </div> <div style="display: flex; justify-content: space-around;"> <span><input type="radio"/> 1st trimester</span> <span><input type="radio"/> After delivery</span> </div> <div style="display: flex; justify-content: space-around;"> <span><input type="radio"/> 2nd trimester</span> <span><input type="radio"/> U/K</span> </div> <input type="radio"/> Other, specify: <input type="radio"/> COVID-19 had no impact on this child's death <input type="radio"/> U/K		h. Did COVID-19 impact the team's ability to conduct this fatality review? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Unable to obtain records <input type="checkbox"/> Team members unable to attend review <input type="checkbox"/> Remote reviews negatively impacted review process <input type="checkbox"/> Team leaders redirected to COVID-19 response																																															
<b>J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)</b> <span style="float:right">This section is skipped for fetal deaths<sup>†</sup></span>																																																	
1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death? <input type="radio"/> Yes/probable <input type="radio"/> No, go to K <input type="radio"/> U/K, go to K		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. <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<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"/>																														
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		3. Did the team have information about the person(s)? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																								
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4. Is person listed in a previous section? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<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"/>	5. Primary person(s) responsible for action(s): Select one for each person responsible. <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<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"/>	<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"/>
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6. Person's age in years: <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	7. Person's sex: <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																
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		8. Person speaks and understands English? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																						
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		9. Person on active military duty? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																						
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10. Person(s) have history of substance abuse? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	11. Person(s) have history of child maltreatment as victim? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																														
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		12. Person(s) have history of child maltreatment as a perpetrator? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																						
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		13. Person(s) have disability or chronic illness? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																						
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14. Person(s) have prior child deaths? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	15. Person(s) have history of intimate partner violence? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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		16. Person(s) have delinquent/criminal history? <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: left;"><u>One</u></th> <th style="width:10%; text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																						
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17. At the time of the incident, was the person asleep?			<u>One</u> <u>Two</u>
<u>One</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<u>Two</u> If yes, select the most appropriate description of the person's sleeping period at incident:	}	<input type="radio"/> Night time sleep <input type="radio"/> Day time nap, describe: <input type="radio"/> Day time sleep (for example, person is night shift worker), describe: <input type="radio"/> Other, describe:

18. At time of incident was person impaired?	19. Person(s) have, check all that apply:	20. Legal outcomes in this death, check all that apply:
<u>One</u> <u>Two</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:	<u>One</u> <u>Two</u> <input type="checkbox"/> Prior history of similar acts <input type="checkbox"/> Prior arrests <input type="checkbox"/> Prior convictions	<u>One</u> <u>Two</u> <input type="checkbox"/> No charges filed <input type="checkbox"/> Charges pending <input type="checkbox"/> Charges filed, specify: <input type="checkbox"/> Charges dismissed <input type="checkbox"/> Confession <input type="checkbox"/> Plead, specify: <input type="checkbox"/> Not guilty verdict <input type="checkbox"/> Guilty verdict, specify: <input type="checkbox"/> Tort charges, specify: <input type="checkbox"/> U/K
<u>One</u> <u>Two</u> <input type="checkbox"/> Drug impaired, specify: <input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Distracted <input type="checkbox"/> Absent	<u>One</u> <u>Two</u> <input type="checkbox"/> Impaired by illness, specify: <input type="checkbox"/> Impaired by disability, specify: <input type="checkbox"/> Other, specify:	

### K. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF THE DEATH

1. Were new or revised services recommended or implemented as a result of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K					
If yes, select one option per row:	Referred for service  <u>before review</u>	Review led to  <u>referral</u>	Referral needed,  <u>not available</u>	<u>N/A</u>	<u>U/K</u>
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Debriefing for professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genetic counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home visiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse	<input type="radio"/>	<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"/>	<input type="radio"/>

### L. FINDINGS IDENTIFIED DURING THE REVIEW

☐ Mark this case to edit/add findings at a later date

1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)		
2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interacted or the response to the incident. (See Data Dictionary for examples).		
3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future:		
4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, select all that apply and describe:		
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Child welfare    Describe:  <input type="checkbox"/> Law enforcement    Describe:  <input type="checkbox"/> Public health    Describe:  <input type="checkbox"/> Coroner/medical examiner    Describe:  <input type="checkbox"/> Courts    Describe:  <input type="checkbox"/> Health care systems    Describe:             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Education    Describe:  <input type="checkbox"/> Mental health    Describe:  <input type="checkbox"/> EMS    Describe:  <input type="checkbox"/> Substance abuse    Describe:  <input type="checkbox"/> Other, specify:    Describe:             </td> </tr> </table>	<input type="checkbox"/> Child welfare    Describe: <input type="checkbox"/> Law enforcement    Describe: <input type="checkbox"/> Public health    Describe: <input type="checkbox"/> Coroner/medical examiner    Describe: <input type="checkbox"/> Courts    Describe: <input type="checkbox"/> Health care systems    Describe:	<input type="checkbox"/> Education    Describe: <input type="checkbox"/> Mental health    Describe: <input type="checkbox"/> EMS    Describe: <input type="checkbox"/> Substance abuse    Describe: <input type="checkbox"/> Other, specify:    Describe:
<input type="checkbox"/> Child welfare    Describe: <input type="checkbox"/> Law enforcement    Describe: <input type="checkbox"/> Public health    Describe: <input type="checkbox"/> Coroner/medical examiner    Describe: <input type="checkbox"/> Courts    Describe: <input type="checkbox"/> Health care systems    Describe:	<input type="checkbox"/> Education    Describe: <input type="checkbox"/> Mental health    Describe: <input type="checkbox"/> EMS    Describe: <input type="checkbox"/> Substance abuse    Describe: <input type="checkbox"/> Other, specify:    Describe:	
5. Could the death have been prevented? <input type="radio"/> Yes, probably <input type="radio"/> No, probably not <input type="radio"/> Team could not determine		

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: <div><input type="checkbox"/> Medical examiner/coroner/pathologist    <input type="checkbox"/> CPS    <input type="checkbox"/> Fire    <input type="checkbox"/> Indian Health Services/ Tribal Health    <input type="checkbox"/> Military <input type="checkbox"/> Death investigator    <input type="checkbox"/> Other social services    <input type="checkbox"/> EMS    <input type="checkbox"/> Home visiting    <input type="checkbox"/> Domestic violence <input type="checkbox"/> Law enforcement    <input type="checkbox"/> Physician    <input type="checkbox"/> Faith based organization    <input type="checkbox"/> Healthy Start    <input type="checkbox"/> Others, list: <input type="checkbox"/> Prosecutor/district attorney    <input type="checkbox"/> Nurse    <input type="checkbox"/> Education    <input type="checkbox"/> Court <input type="checkbox"/> Public health    <input type="checkbox"/> Hospital    <input type="checkbox"/> Mental health    <input type="checkbox"/> Child advocate <input type="checkbox"/> HMO/managed care    <input type="checkbox"/> Other health care    <input type="checkbox"/> Substance abuse</div>		
5. Were the following data sources available at the review meeting? Check all that apply: <b>Vital statistics</b> <input type="checkbox"/> Birth certificate - full form <input type="checkbox"/> Death certificate <b>Health records</b> <input type="checkbox"/> Child's medical records or clinical history, including vaccinations <input type="checkbox"/> Hospital records <input type="checkbox"/> Childbearing parent's obstetric and prenatal information <input type="checkbox"/> Newborn screening results <input type="checkbox"/> Mental health records <input type="checkbox"/> Substance abuse treatment records <b>Investigation records</b> <input type="checkbox"/> Autopsy/pathology reports <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		6. Did any of the following factors reduce meeting effectiveness, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Confidentiality issues among members prevented full exchange of information <input type="checkbox"/> HIPAA regulations prevented access to or exchange of information <input type="checkbox"/> Inadequate investigation precluded having enough information for review <input type="checkbox"/> Team members did not bring adequate information to the meeting <input type="checkbox"/> Necessary team members were absent <input type="checkbox"/> Meeting was held too soon after death <input type="checkbox"/> Meeting was held too long after death <input type="checkbox"/> Records or information were needed from another locality in-state <input type="checkbox"/> Records or information were needed from another state <input type="checkbox"/> Team disagreement on circumstances <input type="checkbox"/> Other factors, specify:
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		

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 MPHI/NCFRP’s data use agreement with your state, HIPAA identifying information should not be recorded in this field.



02. FIMR ISSUES SUMMARY (Ps/Cs)		
P = Present / C = Contributing		
<b>1. Pre-/Inter-/Post-conception Care</b> Y N U Preconception care Y N U Postpartum visit kept Y N U Pregnancy planning/BC education <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After Y N U Dental/oral care <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After Y N U Chronic disease control education <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After Y N U Weight mgmt/dietitian <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After Y N U Bereavement referral <b>2. Medical: Childbearing parent (CBP)</b> P C Early teen (17 and under) pregnancy P C Late teen (18 & 19) pregnancy P C Pregnancy >35 yrs P C Cord problem P C Placental abruption P C Placenta Previa P C Chorioamnionitis P C Pre-existing diabetes P C Gestational diabetes P C Cervical insufficiency P C Previous abnormal PAP P C Infection: BV P C Infection: Group B Strep P C Infection: Urinary tract infection P C STI - _____ P C Other source of infection: _____ P C Multiple gestation # P C Weight: BMI: P C Insufficient/excess weight gain P C Poor nutrition P C Pre-existing hypertension P C Preeclampsia P C Eclampsia P C Preterm labor P C Pregnancy <18 m apart P C PROM P C PPRM P C Prolonged Rupture of Membrane P C Pre-existing dental/oral issues P C Oligo-/Polyhydramnios P C Previous SABs or miscarriages# P C Previous Therapeutic ab #    /Vol ab # P C Previous fetal loss # P C Previous infant loss #_____ P C Previous LBW delivery P C Previous preterm delivery P C VBAC this pregnancy P C Previous C-Section: # P C C-Section this pregnancy P C Previous ectopic pregnancy P C First pregnancy <18 yrs old P C >4 Live births P C Assist reprod tech: P C Other, specify:	<b>3. Family Planning</b> P C Intended pregnancy P C Unintended pregnancy P C Unwanted pregnancy P C No birth control P C Failed contraceptive P C Lack of knowledge: methods P C Lack of resources P C Other, specify: <b>4. Substance Use</b> P C Positive drug test P C No drug test P C Tobacco use: hx, not current P C Tobacco use: current P C Alcohol use: hx, not current P C Alcohol use: current P C Illicit drug use:hx, not current P C Illicit drugs: current: type:_____ P C Use of un-pres meds: type: ____ P C OTC/Rx meds: type: ____ P C Other, specify: <b>5. Prenatal Care/Delivery</b> P C Standard of care not met P C Inadequate assessment P C No prenatal care P C Late entry to prenatal care P C Lack of progesterone therapy P C Lack of referrals P C Missed appointments P C Multiple providers/sites P C Lack of dental assessment P C Lack of dental care P C Inappropriate use of ER P C Other, specify: <b>6. Medical: Fetal/Infant</b> P C Non-viable fetus P C LBW (<2500 grams) P C VLBW (<1500 grams) P C ELBW (<750 grams) P C Intrauterine Growth Restriction P C Congenital anomaly P C Prematurity P C Infection/sepsis P C Failure to thrive P C Birth injury P C Feeding problem P C Respiratory Distress Syndrome P C Developmental delay P C Inappropriate level of care P C Positive drug test P C Other, specify: <b>7. Pediatric Care</b> P C Standard of care not met P C Inadequate assessment P C No pediatric care P C Lack of referrals P C Missed aptmnt/immunizations	<b>7. Pediatric Care (Continued)</b> P C Multiple providers/sites P C Inappropriate use of ER P C Other, specify: <b>8. Environment</b> P C Unsafe neighborhood P C Substandard housing P C Overcrowding P C Second-hand smoke P C Little/no breastfeeding P C Improper formula prep/feeding P C Improper/no car seat use P C Unsafe sleep location P C Objects in sleep environment P C Infant overheating P C Not back sleep position P C Apnea monitor, misuse P C Lack of adult supervision P C Other, specify: <b>9. Injuries</b> P C Suffocation/strangulation P C Abusive head trauma P C General trauma P C Other, specify: <b>10. Social Support</b> P C Lack of family support P C Lack of neighbors/ community support P C Lack of partner support P C Single parent P C Living alone P C <12th grade education P C Special education P C Physical/cognitive disability P C Other, specify: <b>11. Partner/Caregiver</b> P C Employment <input type="radio"/> Yes <input type="radio"/> No P C Hx of mental illness P C Substance or tobacco use/abuse: hx specify: P C Substance or tobacco use/abuse: current specify: P C Other, specify: <b>12. Family Transition</b> P C Frequent/recent moves P C Living in shelter/homeless P C Concern re: citizenship P C Divorce/separation P C Multiple partners P C Prison/parole/probation (CBP) P C Prison/parole/probation (Non-CBP) P C Major illness/death in family P C Other, specify:



13. Mental Health/Stress

- P C Hx of mental illness (CBP)
- P C Depression/anxiety/mental illness during pregnancy
- P C Depression/anxiety/mental illness in postpartum period
- P C Multiple stresses
- P C Social chaos
- P C Employment ☐ Yes ☐ No
- P C Concern about enough money
- P C Work/employment problems
- P C Child(ren) with special needs
- P C Problems with family/relatives
- P C Lack of grief support
- P C Other, specify:

14. Family Violence/Neglect

- Childbearing parent:
- P C Hx of abuse (CBP), specify:
- P C Current abuse (CBP), specify:
- Non-childbearing biological parent:
- P C Hx of abuse (Non-CBP), specify:
- P C Current abuse (Non-CBP), specify:
- P C Hx child abuse: this infant
- P C Hx child abuse: other child
- P C Current child abuse: this infant
- P C Current child abuse: other child
- P C Hx child neglect: this infant
- P C Hx child neglect: other child
- P C Current child neglect: this infant
- P C Current child neglect: other child
- P C CPS referrals
- P C Police reports
- P C Other, specify:

15. Culture

- P C Language barriers
- P C Beliefs re: pregnancy/health
- P C Other, specify:

16. Payment for Care

- P C Private
- P C Medicare
- P C Medicaid
- P C Self-pay/medically indigent
- P C Other, specify:

17. Services Provided

- P C Inadequate information
- P C Lack of WIC (eligible)
- P C Parent/child not eligible
- P C Lack of Home Visiting (eligible)
- P C Poor provider to provider communication
- P C Poor provider to patient communication
- P C Client dissatisfaction
- P C Dissatisfaction – support services
- P C Lack of child care
- P C Other, specify:

18. Transportation

- P C No public transportation
- P C Inadequate/unreliable
- P C Other, specify:

19. Documentation

- P C Inconsistent/unclear information
- P C Missing data
- P C No death scene investigation
- P C No doll re-enactment
- P C Other, specify:

20. Other

- P C Other, specify:

P. FORM COMPLETED BY:

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



The development of this report tool was supported, in part, by Grant No. UG7MC28482 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services and with additional funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health

Data Entry: <https://data.ncfrp.org>

[www.ncfrp.org](http://www.ncfrp.org)    [info@ncfrp.org](mailto:info@ncfrp.org)    1-800-656-2434    Facebook and Twitter: NationalCFRP