OFFICE OF THE IOWA STATE MEDICAL EXAMINER
LUCAS STATE OFFICE BLDG., 321 E. 12TH ST.
DES MOINES, IA 50319-0075

PRELIMINARY REPORT OF CHILD / INFANT DEATH SCENE INVESTIGATION

Please promptly call the Iowa Department of Public Health for notification of all infant deaths. *Call 1-800-383-3826 or fax 515-242-6384. Once completed, this form should be sent directly to the Iowa State Medical Examiner's Office at the address above.

DECEDENT

Name:		**SSN:**
Home Address:		
Date of Birth:	**Date of Death:**	**Time of Death:**

MOTHER

Name:		**SSN:**
Address:		
Date of Birth:	**Other States Where Resided:**	
Telephone #:	**Does mother smoke?** ☐ **Yes** ☐ **No**	
Evidence / History of substance abuse? ☐ **Yes** ☐ **No**		

FATHER

Name:		**SSN:**
Address:		
Date of Birth:	**Other States Where Resided:**	
Telephone #:	**Does father smoke?** ☐ **Yes** ☐ **No**	
Evidence / History of substance abuse? ☐ **Yes** ☐ **No**		

CAREGIVER AT TIME OF DEATH (if other than parent)

Name:		**SSN:**
Address:		
Date of Birth:	**Other States Where Resided:**	
Relationship to Decedent:	**How long cared for child:**	
Telephone #:	**Does this care provider smoke?** ☐ **Yes** ☐ **No**	
Evidence / History of substance abuse? ☐ **Yes** ☐ **No**		

Form ME-4 [Rev. 8/00]

LIST ALL OTHER PERSONS LIVING IN RESIDENCE (OR PRESENT IN RESIDENCE) ON DAY CHILD WAS FOUND UNRESPONSIVE

1] Name:	**Date of Birth:**	**Smoke?** ☐ **Yes** ☐ **No**
2] Name:	**Date of Birth:**	**Smoke?** ☐ **Yes** ☐ **No**
3] Name:	**Date of Birth:**	**Smoke?** ☐ **Yes** ☐ **No**
4] Name:	**Date of Birth:**	**Smoke?** ☐ **Yes** ☐ **No**
5] Name:	**Date of Birth:**	**Smoke?** ☐ **Yes** ☐ **No**

POSITION AT TIME OF DEATH

Who found child? (parent, sitter, etc.)	
Where was child found? (bedroom, crib, etc.)	
Was child moved from original location where found? ☐ **Yes** ☐ **No**	
If yes, by whom?	
In what position found by care provider? (face up, down, side)	
In what position was child placed down? (on stomach, back, side)	
What was child's usual sleep position? (back, side, stomach)	
Was child sleeping with someone else? ☐ **Yes** ☐ **No**	
If yes, with whom?	**Was this usual sleep arrangement?** ☐ **Yes** ☐ **No**
In what condition was child found? (warm, cold, still, mottled, etc.)	

CLOTHING

Describe child's clothing when found:

BEDDING

Describe bed type where child originally found (crib, adult, waterbed, sofa):

Describe bedding type (baby blankets, adult blankets, pillows, etc.):

HOME WHERE FOUND

Type of home where discovered unresponsive (mobile, apt. etc.):	
Condition of home (clean, orderly, etc.):	
Presence or evidence of: **Tobacco smoke?** ☐ **Yes** ☐ **No**	
Drugs? ☐ **Yes** ☐ **No**	**Alcohol?** ☐ **Yes** ☐ **No**
Is there evidence / history of domestic violence in home? ☐ **Yes** ☐ **No**	

HOME TEMPERATURE (where found)

Room temperature: °	**Heating & Cooling system (describe):**

FEEDING HISTORY

When did child last eat?	
What did child last eat?	
Who fed child last?	**Who prepared food?**
Describe normal dietary habits (foods, amounts, etc.)	

RECENT ILLNESS OR INJURY

Child history (fever, vomiting, cold, etc.):		
Recent injury (bruises, cuts, head injury, etc.):		
Recent visit to physician: ☐ **Yes** ☐ **No**	**When?**	**Who?**
Why?		
Does family utilize public services? (check all that apply) ☐ **WIC** ☐ **Medicaid** ☐ **DHS**		

HEALTH INFORMATION

Medicine:	
Allergies:	**Birth Defects:**
Child's primary care physician:	
Last visit to a physician:	**When?** **Why?**

Immunizations current? ☐ Yes ☐ No	When was last one?
If within past month, specify type:	
Does child use any home monitors? ☐ Yes ☐ No	
If yes, was child on home monitor at time of death? ☐ Yes ☐ No	

BIRTH INFORMATION

Birth weight:	Length:	Birth order:
Neonatal complications: ☐ Yes ☐ No If yes, specify:		
Birth order:	Multiple birth: ☐ Yes ☐ No	If yes, ☐ twin ☐ triplet ☐ other
Was infant full term? ☐ Yes ☐ No Gestational age:		
Any illness or complications during pregnancy? ☐ Yes ☐ No		
If yes, what type?		
Any risk factors during pregnancy (alcohol, drugs, tobacco)? ☐ Yes ☐ No		
If yes, what?		

RESUSCITATION

Was basic life support started? ☐ Yes ☐ No	If yes, by whom?

SCENE DOCUMENTATION

Photos of death scene taken? ☐ Yes ☐ No
Video taken? ☐ Yes ☐ No
Property seized? ☐ Yes ☐ No
If yes, what?
What agency seized property?

PERSON COMPLETING FORM

Name (please print or type):	
Agency:	
Telephone #:	FAX #:
Signature:	Date Signed: