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. However, over time abstractors and teams begin to understand the importance of data collection and will make efforts to incorporate necessary information into the case summary. 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. 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.

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 with 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.
### A. CHILD INFORMATION

#### A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

1. **Child's name:** First: ___________ Middle: ___________ Last: ___________ U/K

2. **Date of birth:** U/K
   - mm / dd / yyyy

3. **Date of death:** U/K
   - mm / dd / yyyy

4. **Age:**
   - Months: ___________
   - Days: ___________
   - Hours: ___________
   - Minutes: ___________

5. **Race:**
   - White: Yes
   - Black: No
   - Asian: No
   - American Indian, Tribe: U/K
   - Alaska Native, Tribe: U/K
   - Native Hawaiian or Other Pacific Islander, specify: U/K

6. **Hispanic or Latino origin:**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

7. **Sex:**
   - Male: Yes
   - Female: No
   - U/K: ___________

8. **Residence address:** U/K
   - Street: ___________
   - Apt: ___________
   - City: ___________
   - State: ___________
   - Zip: ___________
   - County: ___________

9. **Child’s weight at death:**
   - Pounds/ounces: ___________
   - Grams/kilograms: ___________

10. **Child’s height at death:**
    - Feet/inches: ___________
    - Cm: ___________

13. **Child had disability or chronic illness?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

   **If yes, check all that apply:**
   - Physical/orthopedic, specify: ___________
   - Mental health/substance abuse, specify: ___________
   - Cognitive/intellectual, specify: ___________
   - Sensory, specify: ___________
   - U/K: ___________

14. **Were any siblings placed outside of the home prior to this child’s death?**
   - N/A: ___________
   - Yes, # ______: ___________
   - No: ___________
   - U/K: ___________

15. **Child's health insurance, check all that apply:**
   - None: ___________
   - Indian Health Service: ___________
   - Private: ___________
   - Other, specify: ___________
   - Medicaid: ___________
   - U/K: ___________
   - State plan: ___________

16. **Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule?**
   - NA: ___________
   - Yes: ___________
   - No: ___________
   - U/K: ___________

17. **Type of residence:**
   - Parental home: Yes
   - Relative home: No
   - Jail/detention: No
   - Licensed group home: Yes
   - Living on own: No
   - Other, specify: ___________
   - Licensed foster home: Yes
   - Homeless: No
   - U/K: ___________

18. **New residence in past 30 days?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

19. **Residence overcrowded?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

20. **Child ever homeless?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

22. **Child had history of child maltreatment?**
   - If yes, check all that apply:
     - N/A: ___________
     - Physical/through CPS: ___________
     - Neglect: ___________
     - Sexual: ___________
     - Emotional/psychological: ___________
     - Psychological: ___________
     - Through CPS referrals: ___________
     - Substantiations: ___________

23. **Was there an open CPS case with child at time of death?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

24. **Was child ever placed outside of the home prior to the death?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

25. **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

Questions 26 - 41 (Section A2) are intentionally skipped.

42. **Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

43. **Gestational age:**
   - U/K: ___________

44. **Birth weight:**
   - U/K: ___________

45. **Multiple gestation?**
   - Yes, # ______: ___________
   - No: ___________
   - U/K: ___________

46. **Including the deceased infant, how many pregnancies did the birth mother have?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

47. **Including the deceased infant, how many live births did the birth mother have?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

48. **Not including the deceased infant, number of children birth mother still has living?**
   - U/K: ___________

49. **Prenatal care provided during pregnancy of deceased infant?**
   - Yes: ___________
   - No: ___________
   - U/K: ___________

   **If yes, number of prenatal visits kept:**
   - U/K: ___________

   **If yes, month of first prenatal visit. Specify 1-9:**
   - U/K: ___________

---

**CASE NUMBER**

____ / ______ / ______ / ______

**State / County or Team Number / Year of Review / Sequence of Review**

**Case Type:**
- Death
- Near death/serious injury
- Not born alive (fetal/stillborn)
- Child never left hospital following birth

**Death Certificate Number:**
- U/K

**Birth Certificate Number:**
- U/K

**ME/Coroner Number:**
- U/K

**Date Team Notified of Death:**
50. Were there access or compliance issues related to prenatal care?  
   - Yes  ☐  No ☐  U/K  ☐  If yes, check all that apply:
     - Lack of money for care  ☐
     - Language barriers  ☐
     - Lack of family/social support  ☐
     - Didn't think she was pregnant  ☐
     - Limitations of health insurance coverage  ☐
     - Couldn't get provider to take as patient  ☐
     - Services not available  ☐
     - Other, specify:  ☐
     - Lack of transportation  ☐
     - Multiple providers, not coordinated  ☐
     - Distrust of health care system  ☐
     - No phone  ☐
     - Couldn't get an earlier appointment  ☐
     - Unwilling to obtain care  ☐
     - Cultural differences  ☐
     - Lack of child care  ☐
     - Didn't know where to go  ☐

52. Did the mother experience any medical complications in previous pregnancies?  
   - N/A  ☐  Yes  ☐  No  ☐  U/K  ☐  If yes, check all that apply:
     - Previous preterm birth  ☐
     - Previous low birth weight birth  ☐
     - Previous large for gestational age (greater than 4000 grams)  ☐

53. Did the mother use any medications, drugs or other substances during pregnancy?  
   - Yes  ☐  No  ☐  U/K  ☐  If yes, check all that apply:
     - Over-the-counter meds  ☐
     - Anti-epileptic  ☐
     - Nausea/vomiting medications  ☐
     - Cocaine  ☐
     - Meds to treat drug addiction  ☐
     - Allergy medications  ☐
     - Anti-hypertensives  ☐
     - Cholesterol medications  ☐
     - Heroin  ☐
     - Opioids  ☐
     - Antibiotics  ☐
     - Anti-hypothyroidism  ☐
     - Sleeping pills  ☐
     - Marijuana  ☐
     - Other pain meds  ☐
     - Anti-flu/antivirals  ☐
     - Arthritis medications  ☐
     - Meds to treat preterm labor  ☐
     - Methamphetamine  ☐
     - Other, specify:  ☐
     - Anti-depressants/anti-anxiety/anti-psychotics  ☐
     - Diabetes medications  ☐
     - Meds used during delivery  ☐
     - Alcohol  ☐
     - Other, specify:  ☐
     - Asthma medications  ☐
     - Progesterone/P17  ☐
     - If alcohol, infant born with fetal effects or syndrome?  ☐
     - Lack of transportation  ☐
     - Multiple providers, not coordinated  ☐
     - Distrust of health care system  ☐
     - No phone  ☐
     - Couldn't get an earlier appointment  ☐
     - Unwilling to obtain care  ☐

56. Level of birth hospital:
   - 1°  ☐
   - 2°  ☐
   - 3°  ☐
   - Free-standing birth hospital  ☐
   - Home birth  ☐
   - Other, specify:  ☐
   - U/K  ☐

57. At discharge from the birth hospital, was a case manager assigned to the mother?  
   - Yes  ☐  No  ☐  U/K  ☐

58. Did the mother attend a postpartum visit?  
   - Yes  ☐  No  ☐  U/K  ☐

59. Did the infant have a NICU stay of more than one day?  
   - Yes  ☐  No  ☐  U/K  ☐

60. Did mother smoke in the 3 months before pregnancy?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, ___ Avg # cigarettes/day:  ☐
   - (20 cigarettes in pack)  ☐
   - U/K quantity  ☐

61. Did the mother smoke at any time during pregnancy?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, Trimester 1  ☐
   - Trimester 2  ☐
   - Trimester 3  ☐
   - Avg # cigarettes/day:  ☐
   - (20 cigarettes in pack)  ☐
   - U/K quantity  ☐

62. Did the mother use e-cigarettes or other electronic nicotine products at any time during pregnancy?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, on average how often?  ☐
   - More than once a day  ☐
   - Once a day  ☐
   - 2-6 days a week  ☐
   - 1 day a week or less  ☐
   - U/K  ☐

63. Was mother injured during pregnancy?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, describe:  ☐

64. Did the mother have postpartum depression?  
   - Yes  ☐  No  ☐  U/K  ☐

65. Did the infant have neonatal abstinence syndrome (NAS)?  
   - Yes  ☐  No  ☐  U/K  ☐

66. Did infant have abnormal metabolic newborn screening results?  
   - N/A  ☐  Yes  ☐  No  ☐  U/K  ☐
   - If yes, describe any abnormality such as a fatty acid oxidation error:  ☐

67. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):
   - None  ☐
   - Cyanosis  ☐
   - Fever  ☐
   - Seizures or convulsions  ☐
   - Excessive sweating  ☐
   - Cardiac abnormalities  ☐
   - Lethargy/sleeping more than usual  ☐
   - Other, specify:  ☐
   - Apnea  ☐
   - Decrease in appetite  ☐

68. In the 72 hours prior to death, did the infant have any of the following? Check all that apply:
   - None  ☐
   - Vomiting  ☐
   - Cyanosis  ☐
   - Choking  ☐
   - Seizures or convulsions  ☐
   - Diarrhea  ☐
   - Other, specify:  ☐
   - Excessive sweating  ☐
   - Difficulty breathing  ☐
   - Stool changes  ☐
   - Fussiness/excessive crying  ☐
   - Decrease in appetite  ☐
   - Apnea  ☐

69. In the 72 hours prior to death, was the infant injured?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, describe cause and injuries:  ☐

70. In the 72 hours prior to death, was the infant given any vaccines?  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, list name(s) of vaccines:  ☐

71. 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.  
   - Yes  ☐  No  ☐  U/K  ☐
   - If yes, list name and last dose given:  ☐

72. What did the infant have for his/her last meal? Check all that apply:
   - Breast milk  ☐
   - Other, specify:  ☐
   - Formula, type:  ☐
   - Baby food, type:  ☐
   - Cereal, type:  ☐
### A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>73. Mother's name: First:</td>
<td>U/K</td>
</tr>
<tr>
<td>74. Father's name: First:</td>
<td>U/K</td>
</tr>
<tr>
<td>75. Mother's country of birth:</td>
<td>U/K</td>
</tr>
<tr>
<td>77. Mother's residence address:</td>
<td>U/K</td>
</tr>
<tr>
<td>78. Mother's marital status during pregnancy:</td>
<td>U/K</td>
</tr>
<tr>
<td>79. Number of months between prior pregnancy and this one:</td>
<td>U/K</td>
</tr>
<tr>
<td>80. Was mother taking folic acid or a multivitamin prior to this pregnancy?</td>
<td>U/K</td>
</tr>
<tr>
<td>81. Mother's employment during pregnancy:</td>
<td>U/K</td>
</tr>
<tr>
<td>82. Mother's pre-pregnancy weight, BMI:</td>
<td>U/K</td>
</tr>
<tr>
<td>83. Mother's pregnancy weight gain or loss in pounds (whole number)</td>
<td>U/K</td>
</tr>
<tr>
<td>84. Did mother achieve the recommended weight gain?</td>
<td>U/K</td>
</tr>
<tr>
<td>85. Mother's age at first pregnancy:</td>
<td>U/K</td>
</tr>
<tr>
<td>86. For each previous pregnancy, describe most recent first:</td>
<td>N/A</td>
</tr>
<tr>
<td>87. Was mother using birth control in the 3 months prior to this pregnancy?</td>
<td>U/K</td>
</tr>
<tr>
<td>88. Where was prenatal care most frequently provided for this pregnancy?</td>
<td>U/K</td>
</tr>
<tr>
<td>89. Which type of provider most frequently provided prenatal care for this pregnancy?</td>
<td>U/K</td>
</tr>
<tr>
<td>90. Was this pregnancy a result of assisted reproductive technology?</td>
<td>U/K</td>
</tr>
<tr>
<td>91. Which of the following tests were performed during this pregnancy?</td>
<td>U/K</td>
</tr>
<tr>
<td>92. Did mother receive the following vaccinations during pregnancy?</td>
<td>U/K</td>
</tr>
</tbody>
</table>

### Table 1: Previous Pregnancy Details

<table>
<thead>
<tr>
<th>Preg #</th>
<th>If in gest.</th>
<th>Baby A, B, C, etc</th>
<th>Year of Delivery</th>
<th>Maternal Age</th>
<th>Gestational age in weeks</th>
<th>Birth weight (grams)</th>
<th>Choose one:</th>
<th>Other</th>
<th>Outcome Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NSVD</td>
<td>C-Sec</td>
<td>VBAC</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
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<td>Y</td>
<td>Y</td>
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<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Test Results

<table>
<thead>
<tr>
<th>Performance</th>
<th>Normal/Abnormal?</th>
<th>Performed</th>
<th>Normal/Abnormal?</th>
<th>Performed</th>
<th>Positive or negative?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N U/K</td>
<td></td>
<td>CBC</td>
<td></td>
<td>CBC</td>
<td>Antibody screen</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>GTT</td>
<td></td>
<td>GTT</td>
<td>STI culture or test</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>HCT/HGB</td>
<td></td>
<td>HCT/HGB</td>
<td>Urine toxicity</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Quad screen, specify abnormal results:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Antepartum fetal surveillance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Fetal movement assessment (kick counts)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Contraction stress test</td>
<td></td>
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</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Nonstress test</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Biophysical profile</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Table 3: Vaccinations

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Performed</th>
<th>Positive or negative?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N U/K</td>
<td></td>
<td>Blood type and Rh factor</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>If yes, what was blood type?</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>If yes, was mother Rh negative?</td>
</tr>
<tr>
<td>OOO</td>
<td></td>
<td>Other, specify test and results (abnormal/positive/etc.):</td>
</tr>
</tbody>
</table>
93. During this pregnancy and including any previous pregnancies, did the mother have any medical conditions/complications?  
Yes  ☐ No  ☐ U/K

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Referrals during this pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy</td>
<td>1 - No referral, not needed</td>
</tr>
<tr>
<td>2 - Began previous to this pregnancy AND includes current pregnancy</td>
<td>2 - No referral, already in care followed through, provider</td>
</tr>
<tr>
<td>3 - Began during this current pregnancy</td>
<td>3 - No referral, needed did not follow through</td>
</tr>
<tr>
<td>4 - Began during labor and delivery</td>
<td>4 - Referral made, no follow through by mother</td>
</tr>
<tr>
<td>9 - U/K</td>
<td>9 - U/K followed through</td>
</tr>
</tbody>
</table>

If yes, check all that apply:

**Cardiovascular**
- Hypertension - gestational
- Hypertension - chronic
- Pre-eclampsia
- Eclampsia
- Clotting disorder

**Hematologic**
- Folic acid deficiency
- Sickle cell disease
- Anemia (iron deficiency)

**Respiratory**
- Asthma
- Pulmonary embolism

**Endocrine/Metabolic**
- Diabetes, type 1 chronic
- Diabetes, type 2 chronic
- Diabetes, gestational
- Thyroid
- Polycystic ovarian disease

**Neurologic/Psychiatric**
- Addiction disorder
- Eating disorder
- Depression
- Anxiety disorder
- Seizure disorder

**Sexually Transmitted Infections (STI)**
- Bacterial vaginosis (BV)
- Chlamydia
- Gonorrhea
- Herpes
- HPV
- Syphilis
- Group B strep
- HIV/AIDS
- Other STI, specify:

**Gynecologic**
- Uterine/vaginal bleeding
- Chorioamnionitis
- Oligohydramnios
- Polyhydramnios
- Intrauterine growth restriction (IUGR)

**Other Complications/Conditions**

94. Did the care provider recommend precautions to prevent premature labor or early labor?  
Yes  ☐ No  ☐ U/K

If yes, what precautions?  
☐ Took medicine to prevent labor or miscarriage
☐ Received progestosterone IM or vaginal progesterone
☐ Stopped or limited sex during pregnancy
☐ Used condoms to prevent infection
☐ Doctor sewed the cervix closed (cerclage of incompetent cervix)
☐ Had bed rest for one or more weeks at home

Was mother able to comply?  
Yes  ☐ No  ☐ U/K

☐ Was hospitalized for one or more nights
☐ Reduced work hours or stopped working earlier than expected
☐ Reduced housework or other physical activities
☐ Other, specify:

95. Type of delivery:  
☐ Routine  
☐ Emergency  
☐ Normal spontaneous vaginal delivery (NSVD)
☐ Vaginal, induced or augmented
☐ Vaginal delivery after C-Section (VBAC)
☐ C-Section
☐ Forceps
☐ Vacuum extraction
☐ U/K

If C-Section, why was it done?  
☐ Failure to progress
☐ Fetal distress
☐ Macrosomia
☐ Placental abruption
☐ Placental Previa
☐ Malpresentation
☐ Repeat C-Section
☐ Other, specify:
96. Were there any signs of fetal distress?  ☐ Yes  ☐ No  ☐ U/K  
If yes, specify: ____________________________

97. Were any birth defects noted?  ☐ Yes  ☐ No  ☐ U/K  
If yes, specify: ____________________________

98. Date of mother’s discharge from the birth hospital:  ☐ N/A  ☐ U/K  
_____ / _____ / ____
mm / dd / yyyy

99. Was there evidence of injury at death, not including the birth process?  ☐ Yes  ☐ No  ☐ U/K  
If yes, what type(s) of injury?  
☐ Contusion/bruises  ☐ Abrasions/scratches  
☐ Fractures  ☐ Resuscitative marks  
☐ Cigarette burns  ☐ Other, specify: ____________________________

100. Was a placental pathology performed?  ☐ Yes  ☐ No  ☐ U/K  
If yes, describe findings: ____________________________

101. Payer source for mother’s care for the following timeframes (check all that apply):  

<table>
<thead>
<tr>
<th>Pre</th>
<th>Preg</th>
<th>L&amp;D</th>
<th>Post</th>
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</table>

102. Did the mother have stable housing during the pregnancy?  ☐ Yes  ☐ No  ☐ U/K  
If no, indicate the type(s) of instability:  
☐ Mother in jail  ☐ Homeless  
☐ Eviction(s)  ☐ More than 3 moves in past year  
☐ Other, specify: ____________________________

103. Did the mother have phone service during the pregnancy?  
☐ Never  ☐ Rarely  ☐ Sometimes  ☐ Most of the time  ☐ Always  ☐ U/K

104. Did the mother have any high-risk prenatal/antepartum encounters?  ☐ Yes  ☐ No  ☐ U/K  
If yes, number of visits with primary care provider: ______
If yes, number of L&D/triage/ED visits, excluding the birth: ______

105. Did the mother have any hospitalizations greater than 24 hours prior to labor and delivery excluding the birth?  ☐ Yes  ☐ No  ☐ U/K  
If yes, what treatment was recommended? ____________________________

106. Were any health education topics discussed at any time between the first prenatal care visit and the delivery?  ☐ Yes  ☐ No  ☐ U/K  
If yes, which topic(s)?  
☐ Maternal signs/symptoms that warrant medical attention  ☐ HIV testing  
☐ Where to go for care in case of maternal emergency  ☐ Mother’s vaccinations  
☐ Current medications  ☐ Risk factors identified by prenatal history  
☐ Environmental/work hazards  ☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)  
☐ Maternal nutrition  ☐ Illicit/recreational drugs  
☐ Weight gain counseling  ☐ Fetal movement monitoring  
☐ Eating disorders such as anorexia or bulimia  ☐ Kick counts  
☐ Exercise  ☐ Choosing how to feed infant/benefits of breastfeeding  
☐ Labor signs  ☐ Preparing to breastfeed  
☐ Signs and symptoms of pregnancy-induced hypertension  ☐ Safe sleep education  

107. Were any health education topics discussed at any time between mother’s admission and discharge from the birth hospital?  ☐ Yes  ☐ No  ☐ U/K  
If yes, which topic(s)?  
☐ Maternal signs/symptoms that warrant medical attention  ☐ Illicit/recreational drugs  
☐ Where to go for care in case of maternal emergency  ☐ Choosing how to feed infant/benefits of breastfeeding  
☐ Current medications  ☐ Breastfeeding education  
☐ Maternal nutrition  ☐ Bottle feeding education  
☐ Eating disorders such as anorexia or bulimia  ☐ Safe sleep education  
☐ Exercise  ☐ Importance of keeping postpartum visits  
☐ HIV testing  ☐ Postpartum (perinatal) depression  
☐ Mother’s vaccinations  ☐ Family planning (spacing, interconception care, etc.)  
☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)  ☐ Other, specify: ____________________________

108. Were any infant safety topics discussed at any time between the first prenatal care visit and mother’s discharge from the birth hospital?  ☐ Yes  ☐ No  ☐ U/K  
If yes, which topic(s)?  
☐ Abusive Head Trauma/Shaken Baby Syndrome  ☐ Use of infant car seat  
☐ Infant care  ☐ SUID/Safe sleep education  
☐ Infant signs/symptoms that warrant medical attention  ☐ Where to go for care in case of infant emergency  
☐ Maternal signs/symptoms that warrant medical attention  ☐ Parenting skills  
☐ Parenting skills  ☐ Small object avoidance  
☐ Protection from falls  ☐ Use of home smoke detector  
☐ Other, specify: ____________________________
109. Did the mother experience any stressors during her pregnancy? 

- [ ] Yes
- [ ] No
- [ ] U/K

If yes, which one(s)?

- [ ] A close family member was very sick
- [ ] Separated or divorced from her husband/partner
- [ ] She lost her job
- [ ] Husband/partner lost his job
- [ ] She and her husband/partner argued more than usual
- [ ] Her husband/partner said he did not want her to be pregnant
- [ ] Financial problems
- [ ] Involved in a physical fight
- [ ] She or her husband/partner went to jail
- [ ] Someone very close to her had a problem with drinking alcohol or drugs
- [ ] Someone very close to her died
- [ ] Afraid of violence in her neighborhood
- [ ] Other, specify:

110. Was the mother a victim of intimate partner violence? * Referral key:

<table>
<thead>
<tr>
<th>Mother as victim:</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconception</td>
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<tr>
<td>Pregnancy</td>
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<tr>
<td>Postpartum</td>
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</tbody>
</table>

Referal:* 1 - No referral, not needed 2 - No referral, already in service 3 - No referral, needed provider did not follow through 4 - Referral made, no follow up by mother 5 - Referral made, mother followed through 6 - Referral made, mother followed through, 7 - Referral made, mother followed through, 8 - Referral made, mother followed through, 9 - U/K

111. Was the family referred to any health or human services program during or after the pregnancy? 

- [ ] Yes
- [ ] No
- [ ] U/K

If any of these are checked, note whether a referral was made using the following responses:

Referral options: 

- [ ] 1 - Referral made, no follow through by mother
- [ ] 2 - Referral made, mother followed through
- [ ] 3 - Referral made, mother followed through but provider did not follow through
- [ ] 4 - Referral made, no follow up by mother
- [ ] 5 - Referral made, mother followed through
- [ ] 6 - Referral made, mother followed through, provider did not follow through
- [ ] 7 - Referral made, mother followed through, provider did not follow through
- [ ] 8 - Referral made, mother followed through, provider did not follow through
- [ ] 9 - U/K

Case management Referral: Drug treatment program Referral: 

- [ ] Infant/child health program Referral: Smoking cessation program Referral: 

- [ ] Child Protection Services Referral: Alcohol cessation program Referral: 

- [ ] Legal aid Referral: Housing authority Referral: 

- [ ] Evidence-based home visiting Referral: Shelters Referral: 

- [ ] Family planning Referral: Unemployment assistance Referral: 

- [ ] Mental health service Referral: Homemaker/home health aide Referral: 

- [ ] Infant mental health program Referral: Medicaid Referral: 

- [ ] Genetic evaluation/counseling Referral: WIC Referral: 

- [ ] GED programs Referral: TANF Referral: 

- [ ] Children's Special Health Care Needs services Referral: SNAP Referral: 

112. 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? 

- [ ] Yes
- [ ] No
- [ ] U/K

If this was a fetal death, go to Section A5.

113. Apgar: 1 min: 5 min: 10 min: 

- [ ] U/K

114. Were neonatal resuscitation measures required or attempted in delivery room? 

- [ ] Yes
- [ ] No
- [ ] U/K

If yes, which measure(s)?

- [ ] Physical stimulation
- [ ] Intubation
- [ ] Respiratory or cardiac meds for resuscitation
- [ ] Oxygen
- [ ] Other, specify:

115. Disposition from delivery room, did the infant go to:

- [ ] Normal newborn nursery
- [ ] Rooming in
- [ ] Observation/special care nursery (NICU, intensive care or premature nursery)
- [ ] Transferred to another hospital
- [ ] Other, specify:

116. 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
- [ ] Hemolysis
- [ ] If yes, due to:

  - [ ] RH
  - [ ] ABO
  - [ ] Other

  If yes, specify highest bilirubin level:

117. 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
- [ ] Benzodiazepines
- [ ] Cocaine
- [ ] Phencyclidine (PCP)
- [ ] Amphetamines
- [ ] Marijuana/THC
- [ ] Opioids, codeine, oxycodone
- [ ] Other, specify:
- [ ] Barbiturates
- [ ] Methadone
- [ ] Heroin
- [ ] U/K
### If the infant never left the hospital following birth, go to Section A5.

118. Date of infant’s last discharge from any hospital: __/__/____  □ U/K

119. Total number of days infant hospitalized: □ U/K

120. Infant’s disposition (after birth, from any hospital):
   - Home with parents  □ Other, specify: □ U/K

121. Did the infant have a primary care provider?  ○ Yes  ○ No  ○ U/K

122. Were any medications prescribed for the infant at any discharge?
   - Yes  □ No  □ U/K
   If yes, specify:
   - Yes  ○ No  ○ U/K
   If yes, were parents instructed in medication administration?
   - Yes  ○ No  ○ U/K

123. Was the infant technologically dependent on discharge from any hospital visit?
   - Yes  ○ No  ○ U/K
   If yes, describe:

124. 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

125. 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”

<table>
<thead>
<tr>
<th>Who saw infant</th>
<th>Age in months</th>
<th>Reason for visit</th>
<th>Recommended treatment</th>
</tr>
</thead>
<tbody>
<tr>
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### A5. FIMR MATERNAL INTERVIEW

126. Was a home interview conducted?  ○ Yes  ○ No, go to Section B

127. Does the mother expect to have any more children?
   - Yes  ○ No  ○ U/K
   If yes, how many? ______  □ U/K
   When: □ U/K

128. Was the mother currently pregnant at time of maternal interview?
   - Yes  ○ No  ○ U/K
   If no, is she currently using birth control?
   - Yes  ○ No  ○ U/K
   If yes, describe type of birth control:

129. How does the mother 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

130. How does the mother describe the time just before her pregnancy?
   - One of the happiest times of her life
   - A happy time with a few problems
   - A moderately hard time
   - A very hard time
   - One of the worst times of her life
   - U/K

131. Did the mother feel she had family or friends who could help with the infant at home?
   - Yes  ○ No  ○ U/K
   If yes, specify who:

132. In the months prior to the infant’s death, how often did the mother feel that daily activities were overwhelming?
   - Never  ○ Sometimes  ○ Very often
   - Almost never  ○ Fairly often  ○ U/K

133. In the months prior to the infant’s death, how often did the mother say that she felt very sad?
   - Never  ○ Fairly often
   - Almost never  ○ Very often
   - Sometimes  ○ U/K

134. According to the mother, was the infant in the same room with someone who was smoking?
   - Yes  ○ No  ○ U/K
   If yes, number of hours per day, maximum 24:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>U/K</th>
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<tbody>
<tr>
<td>135. According to the mother, did she have a crib, Pack 'n Play, bassinet, bed side sleeper or baby box for the infant?</td>
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<tr>
<td>If yes, how often did the infant sleep in it?</td>
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<tr>
<td>Always</td>
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<td>Usually</td>
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<td>Half the time</td>
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<td>Occasionally</td>
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<tr>
<td>Never</td>
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<td>If anything other than “always,” describe where else the infant slept:</td>
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<td>136. Did the mother feel that her infant was ever treated differently or unfairly in getting services?</td>
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<td>If yes, for what reasons?</td>
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<tr>
<td>Race</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>Other, specify:</td>
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<td>Culture/ethnic background</td>
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<td>Citizenship status</td>
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<td>Ability to pay</td>
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<tr>
<td>U/K</td>
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<td>137. How supportive was the father toward the mother during the pregnancy?</td>
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<tr>
<td>Not involved</td>
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<tr>
<td>Supportive</td>
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<td>Unsupportive</td>
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<td>U/K</td>
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<td>138. How satisfied was the mother with the father's contribution(s) toward her or the infant's financial support?</td>
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<td>Very satisfied</td>
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<td>Somewhat satisfied</td>
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<td>Not satisfied</td>
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<tr>
<td>U/K</td>
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<td>139. Were any of the following identified as psychosocial or lifestyle problems experienced by the mother AT ANY TIME in her life, as a child herself, before or during pregnancy or while the infant was still alive?</td>
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<tr>
<td>Mother as a child:</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
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<tr>
<td>If yes, which one(s):</td>
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<tr>
<td>Housing inadequate/homeless</td>
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<td>Food insecurity</td>
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<tr>
<td>Mother treated violently</td>
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<tr>
<td>Parents or caregiver with substance abuse problem</td>
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<td>Parents or caregiver problem drinkers</td>
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<td>Parents or caregiver with mental health problems</td>
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<td>Parental separation or divorce</td>
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<tr>
<td>Incarcerated household member</td>
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<td>Current (during pregnancy or after the birth):</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
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<tr>
<td>If yes, which one(s):</td>
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<tr>
<td>Disturbed mother/infant relationship</td>
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<td>Mother-physical/developmental disability</td>
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<tr>
<td>Husband/partner-physical/developmental disability</td>
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<tr>
<td>Mother-employment/education needs</td>
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<tr>
<td>Husband/partner-employment/education needs</td>
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<tr>
<td>Inadequate support system</td>
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<tr>
<td>Mother or husband/partner felt “stereotyped” or profiled due to race, gender, class, etc.</td>
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<td>140. Did the mother feel that she was ever treated differently or unfairly in getting services?</td>
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<tr>
<td>If yes, for what reasons?</td>
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<td>Race</td>
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<td>Type of insurance</td>
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<td>Citizenship status</td>
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<td>Other, specify:</td>
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<td>Marital status</td>
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<td>U/K</td>
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<tr>
<td>141. During the mother's recent pregnancy, did the mother have others who would have helped her if a problem had come up? (For example, needed a ride to the clinic or needed to borrow money.)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
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<tr>
<td>If yes, describe who would have helped (husband/partner, friend, mother/in-laws, other family, etc.)</td>
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<tr>
<td>142. Did the father experience any stressors during mother's pregnancy?</td>
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<tr>
<td>If yes, which one(s)?</td>
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<tr>
<td>Work or employment problems</td>
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<tr>
<td>Housing problems</td>
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<tr>
<td>Problems with children or other relatives</td>
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<tr>
<td>Other, specify:</td>
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<tr>
<td>Problems with drugs or alcohol</td>
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<tr>
<td>Emotional problems</td>
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<tr>
<td>Problems with the law</td>
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<tr>
<td>Money problems</td>
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<tr>
<td>A death in the family</td>
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<tr>
<td>Health problems</td>
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<tr>
<td>If fetal death or the infant never left the hospital following birth, go to Section B</td>
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<tr>
<td>143. Did the infant ever have an illness for which they weren't seen or treated?</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
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<tr>
<td>If yes, what were the barriers?</td>
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<tr>
<td>Lack of money for care</td>
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<tr>
<td>Limitations of health insurance coverage</td>
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<tr>
<td>Lack of transportation</td>
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<tr>
<td>No phone</td>
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<td></td>
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<tr>
<td>Cultural differences</td>
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<td>Language barriers</td>
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<tr>
<td>Couldn't get provider to take as a patient</td>
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<tr>
<td>Multiple providers, not coordinated</td>
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<tr>
<td>Couldn't get an earlier appointment</td>
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<td></td>
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</tr>
<tr>
<td>Lack of child care (other children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distrust of health care system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwilling to obtain care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did't know where to go</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This space left intentionally blank.
## B. Biological Parent Information

### 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.

- **Female**
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- **Male**
  - Yes [ ]
  - No [ ]
  - U/K [ ]

### 2. Parents' race, check all that apply:

- Female
  - White [ ]
  - Black [ ]
  - Asian, specify: [ ]
  - American Indian, Tribe: [ ]
  - Alaska Native, Tribe: [ ]

- Male
  - White [ ]
  - Black [ ]
  - Asian, specify: [ ]
  - American Indian, Tribe: [ ]
  - Alaska Native, Tribe: [ ]

### 3. Parents' Hispanic or Latino origin?

- Female
  - Yes, specify origin: [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes, specify origin: [ ]
  - No [ ]
  - U/K [ ]

### 4. Parents' age in years at time of child's death:

- Female
  - ________ # Years
  - U/K [ ]

- Male
  - ________ # Years
  - U/K [ ]

### 5. Parents' employment status:

- Female
  - Employed [ ]
  - Unemployed [ ]
  - On disability [ ]

- Male
  - Employed [ ]
  - Unemployed [ ]
  - On disability [ ]

### 6. Parents' income:

- Female
  - High [ ]
  - Medium [ ]
  - Low [ ]
  - U/K [ ]

- Male
  - High [ ]
  - Medium [ ]
  - Low [ ]
  - U/K [ ]

### 7. Parents' education:

- Female
  - < High school [ ]
  - High school/ GED [ ]
  - College [ ]
  - Post graduate [ ]
  - U/K [ ]

- Male
  - < High school [ ]
  - High school/ GED [ ]
  - College [ ]
  - Post graduate [ ]
  - U/K [ ]

### 8. Parents speak and understand English?

- Female
  - Yes [ ]
  - Yes, specify origin: [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes, country of origin: [ ]
  - No [ ]
  - U/K [ ]

### 9. Parents first generation immigrant?

- Female
  - Yes, specify branch: [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes, specify branch: [ ]
  - No [ ]
  - U/K [ ]

### 10. Parents on active military duty?

- Female
  - Yes, specify branch: [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes, specify branch: [ ]
  - No [ ]
  - U/K [ ]

### 11. Parents receive social services in the past twelve months?

- Female
  - WIC [ ]
  - Home visiting, specify: [ ]
  - Social Security Disability Insurance (SSI/SSDI): [ ]
  - TANF [ ]
  - Medicaid [ ]
  - Food stamps/ EBT: [ ]
  - Other, specify: [ ]

- Male
  - WIC [ ]
  - Home visiting, specify: [ ]
  - Social Security Disability Insurance (SSI/SSDI): [ ]
  - TANF [ ]
  - Medicaid [ ]
  - Food stamps/ EBT: [ ]
  - Other, specify: [ ]

### 12. Parents have substance abuse history?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, check all that apply:

- Alcohol [ ]
- Cocaine [ ]
- Marijuana [ ]
- Methamphetamine [ ]
- Opioids [ ]
- Prescription drugs [ ]
- Over-the-counter [ ]
- Other, specify: [ ]
- U/K [ ]

### 13. Parents ever victim of child maltreatment?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, check all that apply:

- Physical [ ]
- Neglect [ ]
- Sexual [ ]
- Emotional/psychological [ ]
- U/K [ ]

### 14. Parents ever perpetrator of maltreatment?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, check all that apply:

- Physical [ ]
- Neglect [ ]
- Sexual [ ]
- Emotional/psychological [ ]
- U/K [ ]

### 15. Parents have disability or chronic illness?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, check all that apply:

- Physical/orthopedic, specify: [ ]
- Mental health/substance abuse, specify: [ ]
- Cognitive/intellectual, specify: [ ]
- Sensory, specify: [ ]
- U/K [ ]

### 16. Parents have prior child deaths?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, cause(s): Check all that apply:

- Child abuse # ______
- Suicide # ______
- Other # ______

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, cause(s): Check all that apply:

- Child abuse # ______
- Suicide # ______
- Other # ______

### 17. Parents have history of intimate partner violence?

- Female
  - Yes, as victim [ ]
  - Yes, as perpetrator [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes, as victim [ ]
  - Yes, as perpetrator [ ]
  - No [ ]
  - U/K [ ]

### 18. Parents have delinquent/criminal history?

- Female
  - Yes [ ]
  - No [ ]
  - U/K [ ]

- Male
  - Yes [ ]
  - No [ ]
  - U/K [ ]

If yes, check all that apply:

- Assaults [ ]
- Robbery [ ]
- Drugs [ ]
- Other, specify: [ ]
- U/K [ ]
C. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two.

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Self, go to Section D</td>
<td>○ Foster parent</td>
</tr>
<tr>
<td>○ Biological mother, go to Section D</td>
<td>○ Mother's partner</td>
</tr>
<tr>
<td>○ Biological father, go to Section D</td>
<td>○ Father's partner</td>
</tr>
<tr>
<td>○ Adoptive parent</td>
<td>○ Grandparent</td>
</tr>
<tr>
<td>○ Stepparent</td>
<td>○ Sibling</td>
</tr>
</tbody>
</table>

2. Caregiver(s) age in years:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Years</td>
</tr>
</tbody>
</table>

3. Caregiver(s) sex:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Male</td>
<td>○ Female</td>
</tr>
</tbody>
</table>

4. Caregiver(s) race, check all that apply:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ White</td>
<td>○ Native Hawaiian</td>
</tr>
<tr>
<td>○ Black</td>
<td>○ Pacific Islander, specify:</td>
</tr>
<tr>
<td>○ Asian, specify:</td>
<td>○ U/K</td>
</tr>
<tr>
<td>○ American Indian, Tribe:</td>
<td>○ U/K</td>
</tr>
<tr>
<td>○ Alaska Native, Tribe:</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

5. Caregiver(s) Hispanic or Latino origin?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
</tbody>
</table>

6. Caregiver(s) employment status:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Employed</td>
<td>○ Unemployed</td>
</tr>
<tr>
<td>○ On disability</td>
<td>○ Stay-at-home</td>
</tr>
<tr>
<td>○ Retired</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

7. Caregiver(s) income:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ High</td>
<td>○ Medium</td>
</tr>
<tr>
<td>○ Low</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

8. Caregiver(s) education:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ High school</td>
<td>○ GED</td>
</tr>
<tr>
<td>○ College</td>
<td>○ Post graduate</td>
</tr>
<tr>
<td>○ U/K</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

9. Do caregiver(s) speak and understand English?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Caregiver(s) first generation immigrant?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes, country of origin:</td>
<td>○ No</td>
</tr>
</tbody>
</table>

11. Caregiver(s) on active military duty?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Caregiver(s) receive social services in the past twelve months?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ WIC</td>
<td>○ Food stamps/SNAP/EBT</td>
</tr>
<tr>
<td>○ Home visiting</td>
<td>○ Section 8/housing</td>
</tr>
<tr>
<td></td>
<td>○ Soc Sec Disability (SSI/SSDI)</td>
</tr>
<tr>
<td>○ TAF</td>
<td>○ Other, specify:</td>
</tr>
<tr>
<td>○ Medicaid</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

13. Caregiver(s) have substance abuse history?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

14. Caregiver(s) ever victim of child maltreatment?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

15. Caregiver(s) ever perpetrator of maltreatment?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

16. Caregiver(s) have disability or chronic illness?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

17. Caregiver(s) have prior child deaths?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

18. Caregiver(s) have history of intimate partner violence?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes, as victim</td>
<td>○ Yes, as perpetrator</td>
</tr>
<tr>
<td>○ No</td>
<td>○ U/K</td>
</tr>
</tbody>
</table>

19. Caregiver(s) have delinquent/criminal history?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ No</td>
</tr>
<tr>
<td></td>
<td>○ U/K</td>
</tr>
</tbody>
</table>
### D. SUPERVISOR INFORMATION

#### 1. Did child have supervision at time of incident leading to death?
- Yes, answer D2-16
- No, not needed given developmental age or circumstances, go to Sec. E
- No, but needed, answer D3-16
- Unable to determine, try to answer D3-16

#### 2. How long before incident did supervisor last see child?
- Child in sight of supervisor
- Minutes _____
- Days _____
- Hours _____

#### 3. Is supervisor listed in a previous section?
- Yes, biological mother, go to D15
- Yes, biological father, go to D15
- Yes, caregiver one, go to D15
- Yes, caregiver two, go to D15
- No

#### 4. Primary person responsible for supervision at the time of incident? Select only one:
- Adoptive parent
- Grandparent
- Institutional staff, go to D15
- Stepparent
- Sibling
- Babysitter
- Foster parent
- Other relative
- Licensed child care worker
- Mother's partner
- Friend
- Other, specify:
- Father's partner
- Acquaintance
- U/K
- Hospital staff, go to D15

#### 5. Supervisor's age in years: _____

#### 6. Supervisor's sex: Male Female U/K

#### 7. Supervisor speaks and understands English? Yes No U/K

#### 8. Supervisor on active military duty? Yes No U/K

#### 9. Supervisor has substance abuse history? Yes No U/K

#### 10. Supervisor has history of child maltreatment? As Victim As Perpetrator
- Yes
- No
- U/K

#### 11. Supervisor has disability or chronic illness? Yes No U/K

#### 12. Supervisor has prior child deaths? Yes No U/K

#### 13. Supervisor has history of intimate partner violence? Yes, as victim Yes, as perpetrator No U/K

#### 14. Supervisor has delinquent or criminal history? Yes No U/K

#### 15. At the time of the incident, was the supervisor asleep? No U/K
- Yes
- No

#### 16. At time of incident was supervisor impaired? No U/K
- Yes
- No

### E. INCIDENT INFORMATION

#### 1. Was the date of the incident the same as the date of death?
- Yes, same as date of death
- No, different than date of death. Enter date of incident: mm / dd / yyyy
- U/K

#### 2. Approximate time of day that incident occurred?
- AM Hour, specify 1-12: U/K
- PM

#### 3. Place of incident, check all that apply:
- Child's home
- Licensed child care center
- Indian reservation/trust lands
- Other parking area
- Friend's home
- Unlicensed child care home
- Military installation
- State or county park
- Licensed foster care home
- Farm/ranch
- Jail/detention facility
- Sports area
- Licensed group home
- School
- Sidewalk
- Other recreation area
- Other, specify:

#### 4. Type of area:
- Urban
- Suburban
- Rural
- Frontier
- U/K
5. Incident state: [ ] Yes [ ] No [ ] U/K
   If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:

6. Incident county:

7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?
   [ ] Yes [ ] No [ ] U/K
   If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):

8. Was the incident witnessed?
   [ ] Yes [ ] No [ ] UK
   If yes, by whom?

9. Was 911 or local emergency called?
   [ ] N/A [ ] Yes [ ] No [ ] U/K

10. Was resuscitation attempted?
    [ ] Yes [ ] No [ ] UK
    If yes, by whom?
    [ ] EMS [ ] Stranger [ ] Other, specify:
    [ ] Parent/relative [ ] Other caretaker/babysitter [ ] Other, specify:
    [ ] Teacher/coach/athletic trainer [ ] Other acquaintance [ ] Other, specify:
    [ ] Health care professional, if death occurred in a hospital setting [ ] Other, specify:

11. At time of incident leading to death, had child used drugs or alcohol?
    [ ] Yes [ ] No [ ] U/K
    If yes, check all that apply:
    [ ] Alcohol [ ] Opioids [ ] Prescription drugs [ ] U/K
    [ ] Cocaine [ ] Marijuana [ ] Over-the-counter drugs [ ] Other, specify:
    [ ] Methamphetamine [ ] Other, specify:

12. Child's activity at time of incident, check all that apply:
    [ ] Sleeping [ ] Working [ ] Driving/vehicle occupant [ ] U/K
    [ ] Playing [ ] Eating [ ] Other, specify:

13. Total number of deaths at incident event, including child:
    [ ] Children, ages 0-18 [ ] U/K
    [ ] Adults

F. INVESTIGATION INFORMATION

1. Was a death investigation conducted?
   [ ] Yes [ ] No [ ] U/K
   If yes, check all that apply:
   [ ] Medical examiner [ ] ME investigator [ ] Law enforcement [ ] EMS [ ] Other, specify:
   [ ] Coroner [ ] Coroner investigator [ ] Fire investigator [ ] Child Protective Services [ ] U/K
   If yes, which of the following death investigation components were completed?
   [ ] Yes [ ] No [ ] U/K
   [ ] CDC’s SUIDI Reporting Form or jurisdictional equivalent
   [ ] Narrative description of circumstances
   [ ] Scene photos
   [ ] Scene recreation with doll
   [ ] Scene recreation without doll
   [ ] Witness interviews
   If yes, shared with review team?
   [ ] Yes [ ] No

2. What additional information would the team like to have known about the death scene investigation?

3. Death referred to:
   [ ] Medical examiner [ ] Not referred
   [ ] Coroner [ ] U/K

4. Person declaring official cause and manner of death:
   [ ] Medical examiner [ ] Hospital physician [ ] Mortician [ ] U/K
   [ ] Coroner [ ] Other physician [ ] Other, specify:

5. Autopsy performed?
   [ ] Yes [ ] No [ ] U/K
   If yes, conducted by:
   [ ] Forensic pathologist [ ] Unknown type pathologist
   [ ] Pediatric pathologist [ ] Other physician
   [ ] General pathologist [ ] Other, specify:
   [ ] U/K
   If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?
   [ ] Yes [ ] No [ ] U/K
   If yes, specify specialist:
   [ ] Yes [ ] No [ ] U/K
   If no, why not (e.g. parent or caregiver objected)?:

6. Were the following assessed either through the autopsy or through information collected prior to the autopsy?
   Please list any abnormalities/significant findings in F10.
   [ ] Yes [ ] No [ ] U/K
   Imaging:
   [ ] X-ray - single
   [ ] X-ray - multiple views
   [ ] X-ray - complete skeletal series
   [ ] Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):
   [ ] Other Autopsy Procedures:
   [ ] Exam of general appearance
   [ ] Head circumference
   [ ] Was a gross examination of organs done?
   [ ] Were weights of any organs taken?

7. Were any of these additional tests performed at or prior to the autopsy?
   Please list any abnormalities/significant findings in F10.
   [ ] Yes [ ] No [ ] U/K
   Cultures for infectious disease
   Microscopic/histologic exam
   Postmortem metabolic screen
   Vitreous testing
   Genetic testing
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Was any toxicology testing performed?</td>
<td></td>
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<tr>
<td>If yes, what were the results?</td>
<td></td>
<td></td>
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<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too high Rx drug, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
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<tr>
<td>9. What was the child's medical history reviewed as part of the autopsy?</td>
<td></td>
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</tr>
<tr>
<td>If yes, did this include:</td>
<td></td>
<td></td>
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<tr>
<td>Review of the newborn metabolic screen results?</td>
<td></td>
<td></td>
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<tr>
<td>Review of neonatal CCHD screen results?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Describe any abnormalities or other significant findings noted in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the autopsy:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. What additional information would the team like to have known about</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the autopsy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Was there agreement between the cause of death listed on the autopsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>report and on the death certificate?</td>
<td></td>
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</tr>
<tr>
<td>If no, describe the differences:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Was a CPS record check conducted as a result of death?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>14. Did any investigation find evidence of prior abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
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<tr>
<td>CPS review</td>
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<tr>
<td>Law enforcement</td>
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<tr>
<td>15. CPS action taken because of death?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, highest level of action taken because of death:</td>
<td></td>
<td></td>
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<tr>
<td>Report screened out and not investigated</td>
<td></td>
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<tr>
<td>Unsubstantiated</td>
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<tr>
<td>Inconclusive</td>
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<tr>
<td>Substantiated</td>
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<tr>
<td>If yes, what services or actions resulted? Check all that apply:</td>
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<tr>
<td>Voluntary services offered</td>
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<tr>
<td>Voluntary services provided</td>
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<tr>
<td>Court-ordered services provided</td>
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<tr>
<td>Voluntary out of home placement</td>
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<tr>
<td>Children removed</td>
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<tr>
<td>Parental rights terminated</td>
<td></td>
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<tr>
<td>16. If death occurred in licensed setting (see E3), indicate action taken:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No action</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>License suspended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>License revoked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigation ongoing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17. What additional information would the team like to have known about</td>
<td></td>
<td></td>
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<tr>
<td>the autopsy?</td>
<td></td>
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<tr>
<td>18. Was any toxicology testing performed?</td>
<td></td>
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<tr>
<td>If yes, what were the results?</td>
<td></td>
<td></td>
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<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Methamphetamine</td>
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<td></td>
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<tr>
<td>Too high Rx drug, specify:</td>
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<td></td>
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<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
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<tr>
<td>19. Was the child's medical history reviewed as part of the autopsy?</td>
<td></td>
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<tr>
<td>If yes, did this include:</td>
<td></td>
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<tr>
<td>Review of the newborn metabolic screen results?</td>
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<tr>
<td>Review of neonatal CCHD screen results?</td>
<td></td>
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<tr>
<td>20. Describe any abnormalities or other significant findings noted in</td>
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<tr>
<td>the autopsy:</td>
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<tr>
<td>21. What additional information would the team like to have known about</td>
<td></td>
<td></td>
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<tr>
<td>the autopsy?</td>
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<tr>
<td>22. Was there agreement between the cause of death listed on the autopsy</td>
<td></td>
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<tr>
<td>report and on the death certificate?</td>
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<tr>
<td>If no, describe the differences:</td>
<td></td>
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<tr>
<td>23. Was a CPS record check conducted as a result of death?</td>
<td></td>
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<tr>
<td>24. Did any investigation find evidence of prior abuse?</td>
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<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CPS review</td>
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<td></td>
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<tr>
<td>Law enforcement</td>
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<tr>
<td>25. CPS action taken because of death?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, highest level of action taken because of death:</td>
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<td></td>
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<tr>
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<tr>
<td>Substantiated</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Voluntary out of home placement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children removed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental rights terminated</td>
<td></td>
<td></td>
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<tr>
<td>26. If death occurred in licensed setting (see E3), indicate action taken:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No action</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>License suspended</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>License revoked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigation ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### H1. MOTOR VEHICLE AND OTHER TRANSPORT

**a. Vehicles involved in incident:**

<table>
<thead>
<tr>
<th>Child's Other primary vehicle</th>
<th>Total number of vehicles: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Car</td>
<td></td>
</tr>
<tr>
<td>Van</td>
<td></td>
</tr>
<tr>
<td>Sport utility vehicle</td>
<td></td>
</tr>
<tr>
<td>Truck</td>
<td></td>
</tr>
<tr>
<td>Semi/tractor trailer</td>
<td></td>
</tr>
<tr>
<td>RV</td>
<td></td>
</tr>
<tr>
<td>School bus</td>
<td></td>
</tr>
<tr>
<td>Other bus</td>
<td></td>
</tr>
<tr>
<td>Motorcycle</td>
<td></td>
</tr>
<tr>
<td>Tractor</td>
<td></td>
</tr>
<tr>
<td>Other farm vehicle</td>
<td></td>
</tr>
<tr>
<td>All terrain vehicle</td>
<td></td>
</tr>
<tr>
<td>Snowmobile</td>
<td></td>
</tr>
<tr>
<td>Bicycle</td>
<td></td>
</tr>
<tr>
<td>Train</td>
<td></td>
</tr>
<tr>
<td>Subway</td>
<td></td>
</tr>
<tr>
<td>Trolley</td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
</tr>
<tr>
<td>U/K</td>
<td></td>
</tr>
</tbody>
</table>

**b. Position of child:**

- Driver
- Passenger
- If passenger, relationship of driver to child:
  - Front seat
  - Back seat
  - Truck bed
  - Other, specify:
  - On bicycle
  - Pedestrian
  - Walking
  - Boarding/blading
  - U/K
  - Other, specify:
  - UK

**c. Causes of incident, check all that apply:**

- Speeding over limit
- Back/front over
- Unsafe speed for conditions
- Flipover
- Recklessness
- Poor sight line
- Ran stop sign or red light
- Car changing lanes
- Driver distraction
- Road hazard
- Driver inexperience
- Animal in road
- Mechanical failure
- Cell phone use while driving
- Poor tires
- Racing, not authorized
- Poor weather
- Other driver error, specify:
- Poor visibility
- Drugs or alcohol use
- Other, specify:
- Fatigue/sleeping
- Medical event, specify:
- U/K

**d. Collision type:**

- Child not in/on a vehicle, but struck by vehicle
- Child in/on a vehicle, struck by other vehicle
- Child in/on a vehicle, struck by another vehicle
- Child in/on a vehicle that struck other vehicle
- Child in/on a vehicle that struck person/object

**e. Driving conditions, check all that apply:**

- Normal
- Loose gravel
- Muddy
- Other, specify:
- Fog
- Ice/snow
- U/K
- Wet

**f. Location of incident, check all that apply:**

- City street
- Driveway
- Residential street
- Parking area
- Rural road
- Off road
- Highway
- RR xing/tracks
- Intersection
- Other, specify:
- Shoulder
- Sidewalk
- U/K
- Construction zone

**g. Drivers involved in incident, check all that apply:**

**Child as driver**

<table>
<thead>
<tr>
<th>Age of Driver</th>
<th>Driver of other primary vehicle</th>
<th>Child as driver</th>
<th>Child's driver</th>
<th>Driver of other primary vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 16 years</td>
<td></td>
<td></td>
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<tr>
<td>16 to 18 years old</td>
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<tr>
<td>19 to 21 years old</td>
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<tr>
<td>22 to 29 years old</td>
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<tr>
<td>30 to 65 years old</td>
<td></td>
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<tr>
<td>&gt; 65 years old</td>
<td>U/K age</td>
<td></td>
<td></td>
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<tr>
<td>Responsible for causing incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was alcohol/drug impaired</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Has no license</td>
<td></td>
<td></td>
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<tr>
<td>Has a learner’s permit</td>
<td></td>
<td></td>
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<tr>
<td>Has a graduated license</td>
<td></td>
<td></td>
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<tr>
<td>Has a full license</td>
<td></td>
<td></td>
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<tr>
<td>Has a full license that has been restricted</td>
<td></td>
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<tr>
<td>Has a suspended license</td>
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<tr>
<td>If recreational vehicle, has driver safety certificate</td>
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<tr>
<td>Other, specify:</td>
<td></td>
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<tr>
<td>Was violating graduated licensing rules:</td>
<td></td>
<td></td>
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<tr>
<td>Nighttime driving curfew</td>
<td></td>
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<tr>
<td>Passenger restrictions</td>
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<tr>
<td>Driving without required supervision</td>
<td></td>
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<tr>
<td>Other violations, specify:</td>
<td></td>
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</tbody>
</table>

**h. Total number of occupants in vehicles:**

**In child’s vehicle, including child:**

- N/A, child was not in a vehicle
- U/K

- Total number of occupants: ______
- Number of teens, ages 14-21: ______
- Total number of deaths: ______
- Total number of teen deaths: ______

**In other primary vehicle involved in incident:**

- N/A, incident was a single vehicle crash
- U/K

- Total number of occupants: ______
- Number of teens, ages 14-21: ______
- Total number of deaths: ______
- Total number of teen deaths: ______

**i. Protective measures for child, select one option per row:**

<table>
<thead>
<tr>
<th>Not Needed, none present</th>
<th>Present, used correctly</th>
<th>Present, used incorrectly</th>
<th>Present, not used</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airbag</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lap belt</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shoulder belt</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Child seat*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Belt positioning booster seat</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Helmet</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### H2. FIRE, BURN, OR ELECTROCUTION

**a. Ignition, heat or electrocution source:**
- [ ] Matches
- [ ] Cigarette lighter
- [ ] Utility lighter
- [ ] Cigarette or cigar
- [ ] Candies
- [ ] Cooking stove
- [ ] Electrical outlet
- [ ] Firework
- [ ] Other explosives
- [ ] Heating stove
- [ ] Space heater
- [ ] Furnace
- [ ] Power line
- [ ] Electrical outlet
- [ ] Other hot liquid, specify:
- [ ] Electric probed into

**b. Type of incident:**
- [ ] Fire, go to c
- [ ] Scald, go to r
- [ ] Other burn, go to t
- [ ] Electrocution, go to s
- [ ] Other, specify and go to t

**c. For fire, child died from:**
- [ ] Burns
- [ ] Smoke inhalation
- [ ] Other, specify:

**d. Material first ignited:**
- [ ] Upholstery
- [ ] Mattress
- [ ] Clothing
- [ ] Curtain
- [ ] Other, specify:

**e. Type of building on fire:**
- [ ] N/A
- [ ] Single home
- [ ] Duplex
- [ ] Apartment
- [ ] Trailer/mobile home
- [ ] Other, specify:

**f. Building’s primary construction material:**
- [ ] Wood
- [ ] Steel
- [ ] Brick/stone
- [ ] Aluminum
- [ ] Other, specify:

**g. Fire started by a person?**
- [ ] Yes
- [ ] No

If yes, person’s age _____

Does person have a history of setting fires?
- [ ] Yes
- [ ] No
- [ ] U/K

**h. Did anyone attempt to put out fire?**
- [ ] Yes
- [ ] No
- [ ] U/K

**i. Did escape or rescue efforts worsen fire?**
- [ ] Yes
- [ ] No
- [ ] U/K

**j. Did any factors delay fire department arrival?**
- [ ] Yes
- [ ] No
- [ ] U/K

**k. Were barriers preventing safe exit?**
- [ ] Yes
- [ ] No
- [ ] U/K

If yes, check all that apply:
- [ ] Locked door
- [ ] Window grate
- [ ] Locked window
- [ ] Blocked stairway
- [ ] Other, specify:

**l. Was building a rental property?**
- [ ] Yes
- [ ] No
- [ ] U/K

If yes, check all that apply:
- [ ] Locked door
- [ ] Window grate
- [ ] Locked window
- [ ] Blocked stairway
- [ ] Other, specify:

**m. Were building/rental codes violated?**
- [ ] Yes
- [ ] No
- [ ] U/K

If yes, describe in narrative.

**n. Were proper working fire extinguishers present?**
- [ ] Yes
- [ ] No
- [ ] U/K

If yes, check all that apply:
- [ ] Sprinkler present?
- [ ] Smoke alarms present?
  - [ ] Yes
  - [ ] No
  - [ ] U/K

If yes, what type?
- [ ] Removable batteries
- [ ] Non-removable batteries
- [ ] Hardwired
- [ ] Other, specify:

If not functioning properly, reason:
- [ ] Missing batteries
- [ ] Other
- [ ] U/K

**q. Suspected arson?**
- [ ] Yes
- [ ] No
- [ ] U/K

If yes, check all that apply:
- [ ] Locked door
- [ ] Window grate
- [ ] Locked window
- [ ] Blocked stairway
- [ ] Other, specify:

**r. For scald, was hot water heater set too high?**
- [ ] N/A
- [ ] Yes, temp. setting: ____
- [ ] No
- [ ] U/K

**s. For electrocution, what cause:**
- [ ] Electrical storm
- [ ] Faulty wiring
- [ ] Wire/product in water
- [ ] Child playing with outlet
- [ ] Other, specify:

**t. Other, describe in detail:**

---

### H3. DROWNING

**a. Where was child last seen before drowning?**
- [ ] In water
- [ ] In yard
- [ ] On shore
- [ ] In bathroom
- [ ] On dock
- [ ] In house
- [ ] Poolside
- [ ] Other, specify:

**b. What was child last seen doing before drowning?**
- [ ] Playing
- [ ] Tubing
- [ ] Boating
- [ ] Water skiing
- [ ] Swimming
- [ ] Sleepness
- [ ] Bathing
- [ ] Other, specify:
- [ ] Fishing
- [ ] Surfing

**c. Was child forcibly submerged?**
- [ ] Yes
- [ ] No
- [ ] U/K

**d. Drowning location:**
- [ ] Open water, go to e
- [ ] Pool, hot tub, spa, go to i
- [ ] Bathtub, go to w
- [ ] Bucket, go to x
- [ ] Well/cistern/septic, go to n
- [ ] Toilet, go to z
- [ ] Other, specify and go to n

**e. For open water, place:**
- [ ] Lake
- [ ] Quarry
- [ ] River
- [ ] Gravel pit
- [ ] Pond
- [ ] Canal
- [ ] Creek
- [ ] Ocean
- [ ] U/K

**f. For open water, contributing environmental factors:**
- [ ] Weather
- [ ] Drop off
- [ ] Temperature
- [ ] Rough waves
- [ ] Current
- [ ] Other, specify:
- [ ] Rip tide/undertow

**g. If boating, type of boat:**
- [ ] Sailboat
- [ ] Commercial
- [ ] Jet ski
- [ ] Motorboat
- [ ] Canoe
- [ ] Kayak
- [ ] Raft

**h. For boating, was the child piloting boat?**
- [ ] Yes
- [ ] No
- [ ] U/K

**i. For pool, type of pool:**
- [ ] Above ground
- [ ] In-ground
- [ ] Hot tub, spa
- [ ] Wading
- [ ] U/K

**j. For pool, child found:**
- [ ] In the pool/hot tub/spa
- [ ] On or under the cover
- [ ] Under
cover
- [ ] U/K

**k. For pool, ownership is:**
- [ ] Private
- [ ] Public
- [ ] U/K

**l. Length of time owners had pool/hot tub/spa:**
- [ ] N/A
- [ ] >1yr
- [ ] 6m-1 yr
- [ ] U/K

---

**Page 17 of 28**
### m. Flotation device used?

- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, check all that apply:

- [ ] Coat Guard approved  
- [ ] Life jacket  
- [ ] Cushion  
- [ ] Lifesaving ring  
- [ ] Swimming ring  
- [ ] Inner tube  
- [ ] Air mattress  
- [ ] Other, specify:

Not Coast Guard approved  
- [ ] U/K

If jacket:

- [ ] Correct size?  
- [ ] Yes  
- [ ] No  
- [ ] U/K  
- [ ] Worn correctly?  
- [ ] Yes  
- [ ] No  
- [ ] U/K

### n. What barriers/layer of protection existed to prevent access to water?

Check all that apply:

- [ ] None  
- [ ] Alarm, go to r  
- [ ] Fence, go to o  
- [ ] Cover, go to s  
- [ ] Gate, go to p  
- [ ] Door, go to q  
- [ ] U/K

### o. Fence:

- Describe type:

Fence height in ft _____

Fence surrounds water on:

- [ ] Four sides  
- [ ] Two or less sides  
- [ ] Three sides  
- [ ] U/K

- [ ] U/K

Correct size?  
- [ ] Yes  
- [ ] No  
- [ ] U/K

Worn correctly?  
- [ ] Yes  
- [ ] No  
- [ ] U/K

### p. Gate, check all that apply:

- [ ] Has self-closing latch  
- [ ] Has lock  
- [ ] Is a double gate  
- [ ] Opens to water  
- [ ] U/K

- [ ] Gap in gate  
- [ ] Climbed fence  
- [ ] U/K

### q. Door, check all that apply:

- [ ] Patio door  
- [ ] Screen door  
- [ ] Barrier between door and water  
- [ ] Steel door  
- [ ] Self-closing  
- [ ] U/K  
- [ ] Has lock  
- [ ] U/K

### r. Alarm, check all that apply:

- [ ] Door  
- [ ] Window  
- [ ] Pool  
- [ ] Laser  
- [ ] U/K

### t. Local ordinance(s) regulating access to water?

- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, rules violated?

- [ ] Yes  
- [ ] No  
- [ ] U/K

### u. How were layers of protection breached? Check all that apply:

- [ ] No layers breached  
- [ ] Gate left open  
- [ ] Gate unlocked  
- [ ] Gate latch failed  
- [ ] Gap in gate  
- [ ] Climbed fence  
- [ ] Door broken  
- [ ] Alarm not working  
- [ ] U/K

- [ ] Door screen torn  
- [ ] Door self-closer failed  
- [ ] Cover left off  
- [ ] Cover not locked  
- [ ] U/K

### v. Child able to swim?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

If yes, specify type:

### w. For bathtub, child in a bathing aid?

- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, specify type:

### x. Warning sign or label posted?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

### y. Lifeguard present?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

### z. Rescue attempt made?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

If yes, who? Check all that apply:

- [ ] Parent  
- [ ] Bystander  
- [ ] Other child  
- [ ] Other, specify:

- [ ] Lifeguard  
- [ ] U/K

### aa. Did rescuer(s) also drown?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

If yes, number of rescuers that drowned: __________

### bb. Appropriate rescue equipment present?

- [ ] N/A  
- [ ] No  
- [ ] Yes  
- [ ] U/K

### H4. UNINTENTIONAL ASPHYXIA

#### a. Type of event:

- [ ] Suffocation, go to b
- [ ] Strangulation, go to c  
- [ ] Choking, go to d
- [ ] Other, specify and go to e

- [ ] U/K, go to e

#### b. If suffocation/asphyxia, action causing event:

- [ ] Confined in tight space  
- [ ] Swaddled in tight blanket, but not sleep-related
- [ ] Wedged into tight space, but not sleep-related, specify:  
- [ ] Refrigerator/freezer  
- [ ] Toy chest  
- [ ] Automobile  
- [ ] U/K

- [ ] Other, specify:

- [ ] Trunk  
- [ ] Other, specify:  
- [ ] U/K

#### c. If strangulation, object causing event:

- [ ] Clothing  
- [ ] Leash  
- [ ] Blind cord  
- [ ] Electrical cord  
- [ ] Car seat  
- [ ] Person, go to H5q
- [ ] Stroller  
- [ ] Automobile power window  
- [ ] High chair  
- [ ] Sunroof or window
- [ ] Belt  
- [ ] Other, specify:

- [ ] Rope/string  
- [ ] U/K

#### d. If choking, object causing choking:

- [ ] Food, specify:
- [ ] Toy, specify:
- [ ] Balloon  
- [ ] Other, specify:

- [ ] U/K

#### e. Was asphyxia an autoerotic event?

- [ ] N/A  
- [ ] Yes  
- [ ] No  
- [ ] U/K

### g. History of seizures?

- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, #_____

#### f. Was child participating in "choking game" or "pass out game"?

- [ ] N/A  
- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, witnessed?  
- [ ] Yes  
- [ ] No  
- [ ] U/K

#### h. History of apnea?

- [ ] Yes  
- [ ] No  
- [ ] U/K

If yes, witnessed?  
- [ ] Yes  
- [ ] No  
- [ ] U/K

#### i. Was Heimlich Maneuver attempted?

- [ ] Yes  
- [ ] No  
- [ ] U/K
### H5. Assault, Weapon or Person's Body Part

**a. Type of weapon:**
- ☐ Firearm, go to b
- ☐ Sharp instrument, go to j
- ☐ Blunt instrument, go to k
- ☐ Person's body part, go to l
- ☐ Explosive, go to m
- ☐ Rope, go to m
- ☐ Pipe, go to m
- ☐ Biological, go to m
- ☐ Other, specify and go to m
- U/K, go to m

**b. For firearms, type:**
- ☐ Handgun
- ☐ Shotgun
- ☐ BB gun
- ☐ Hunting rifle
- ☐ Assault rifle
- ☐ Air rifle
- ☐ Sawed off shotgun
- ☐ U/K

**c. Firearm licensed?**
- ☐ Yes
- ☐ No
- ☐ U/K

**d. Firearm safety features, check all that apply:**
- ☐ Trigger lock
- ☐ Personalization device
- ☐ Minimum trigger pull
- ☐ External safety/drop safety
- ☐ Other, specify:
- ☐ Loaded chamber indicator
- ✔ U/K

**e. Where was firearm stored?**
- ☐ Not stored
- ☐ Under mattress/pillow
- ☐ Locked cabinet
- ☐ Other, specify:
- ☐ Unlocked cabinet
- ☐ Glove compartment
- ☐ U/K

**f. Firearm stored with ammunition?**
- ☐ Yes
- ☐ No
- ☐ U/K

**g. Firearm stored loaded?**
- ☐ Yes
- ☐ No
- ☐ U/K

**h. Owner of fatal firearm:**
- ☐ U/K, weapon stolen
- ☐ U/K, weapon found
- ☐ Self
- ☐ Biological parent
- ☐ Adoptive parent
- ☐ Stepparent
- ☐ Foster parent
- ☐ Mother's partner
- ☐ Father's partner
- ☐ Classmate
- ☐ U/K

**i. Sex of fatal firearm owner:**
- ☐ Male
- ☐ Female
- ☐ U/K

**j. Type of sharp object:**
- ☐ Kitchen knife
- ☐ Switchblade
- ☐ Pocketknife
- ☐ Razor
- ☐ Hunting knife
- ☐ Scissors
- ☐ Other, specify:
- ☐ U/K

**k. Type of blunt object:**
- ☐ Bat
- ☐ Club
- ☐ Stick
- ☐ Hammer
- ☐ Rock
- ☐ Household item
- ☐ Other, specify:
- ☐ U/K

**l. What did person's body part do? Check all that apply:**
- ☐ Beat, kick or punch
- ☐ Drop
- ☐ Push
- ☐ Bite
- ☐ Shake
- ☐ Strangle/choke
- ☐ Throw
- ☐ Drown
- ☐ Burn
- ☐ Other, specify:
- ☐ U/K

**m. Did person using weapon have history of weapon-related offenses?**
- ☐ Yes
- ☐ No
- ☐ U/K

**n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?**
- ☐ Yes, describe circumstances:
- ☐ U/K

**o. Persons handling weapons at time of incident, check all that apply:**
- ☐ Self injury
- ☐ Commission of crime
- ☐ Drug dealing/trading
- ☐ Drive-by shooting
- ☐ Random violence
- ☐ Child was a bystander
- ☐ Argument
- ☐ Jealousy
- ☐ Intimate partner violence
- ☐ Hate crime
- ☐ Bullying
- ☐ Hunting
- ☐ Target shooting
- ☐ Playing with weapon
- ☐ Weapon mistaken for toy
- ☐ Showing gun to others
- ☐ Loading weapon
- ☐ Intervener assisting crime victim (Good Samaritan)
- ☐ Other, specify:
- ☐ U/K

**p. Sex of person(s) handling weapon:**
- ☐ Male
- ☐ Female
- ☐ U/K

### H6. Fall or Crush

**a. Type:**
- ☐ Fall, go to b
- ☐ Crush, go to h

**b. Height of fall:**
- ☐ Open window
- ☐ Screen
- ☐ No screen
- ☐ U/K if screen
- ☐ Natural elevation
- ☐ Stairs/steps
- ☐ Moving object, specify:
- ☐ Animal, specify:
- ☐ U/K

**c. Child fell from:**
- ☐ Screen?
- ☐ U/K
- ☐ Man-made elevation
- ☐ Furniture
- ☐ Bridge
- ☐ Playground equipment
- ☐ Bed
- ☐ Overpass
- ☐ Tree
- ☐ Roof
- ☐ Balcony
- ☐ U/K

---

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**Surface child fell onto:**

- Cement/concrete
- Linoleum/vinyl
- Grass
- Marble/tile
- Gravel
- Other, specify:
- Wood floor
- Carpeted floor
- U/K

**Barrier in place, check all that apply:**

- None
- Stairway
- Screen
- Gate
- Other window guard
- Other, specify:
- Fence
- U/K
- Railing
- U/K

**For crush, did child:**

- Climbed up on object
- Pulled object down
- Hid behind object
- Go behind object
- Fell out of object
- Other, specify:
- U/K

**For crush, object causing crush:**

- Appliance
- Boulders/rocks
- Television
- Dirt/sand
- Furniture
- Person, go to H5q
- Walls
- Commercial
- Playground equipment
- Farm equipment
- Animal
- Other, specify:
- Tree branch
- U/K

**Was child pushed, dropped or thrown?**

- Yes
- No
- U/K

**If yes, go to H5q**

**Was child pushed, dropped or thrown?**

- Yes
- No
- U/K

**Other, specify:**

- Equipment
- Farm equipment
- Oil
- Other

**Was child pushed, dropped or thrown?**

- Yes
- No
- U/K

**Other, specify:**

- Equipment
- Farm equipment
- Oil
- Other

**Was child pushed, dropped or thrown?**

- Yes
- No
- U/K

**Other, specify:**

- Equipment
- Farm equipment
- Oil
- Other

### H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

**a. Type of substance involved, check all that apply and note source of substance:**

<table>
<thead>
<tr>
<th>Source codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bought from dealer or stranger (Prescription or illicit only)</td>
</tr>
<tr>
<td>2</td>
<td>Bought from friend or relative</td>
</tr>
<tr>
<td>3</td>
<td>From friend or relative for free</td>
</tr>
<tr>
<td>4</td>
<td>Took from friend or relative without asking</td>
</tr>
<tr>
<td>5</td>
<td>Own prescription (Prescription only)</td>
</tr>
<tr>
<td>6</td>
<td>Bought from store/pharmacy (OTC or other substances only)</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
<tr>
<td>8</td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>

**b. Where was the substance stored?**

- Open area
- Open cabinet
- Closed cabinet, unlocked
- Closed cabinet, locked
- Other, specify:
- U/K

**c. Was the product in its original container?**

- Yes
- No
- U/K

**d. Did container have a child safety cap?**

- Yes
- No
- U/K

**e. Was the incident the result of?**

- Accidental overdose
- Medical treatment mishap
- Adverse effect, but not overdose
- Deliberate poisoning
- Acute intoxication
- Other, specify:
- U/K

**f. Was Poison Control called?**

- Yes
- No
- U/K

**g. For CO poisoning, was a CO alarm present?**

- Yes
- No
- U/K

**H8. MEDICAL CONDITION**

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

- In utero
- Weeks
- Since birth
- Months
- Hours
- Years
- Days
- U/K

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

- Yes
- No
- U/K

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

- Yes
- No
- U/K

**d. Were the prescribed care plans appropriate for the medical condition?**

- Yes
- No
- U/K

**e. Was child/family compliant with the prescribed care plans?**

- Yes
- No
- U/K

**f. Was the medical condition associated with an outbreak?**

- Yes
- No
- U/K

**g. Was environmental tobacco exposure a contributing factor in death?**

- Yes
- No
- U/K

**h. Were there access or compliance issues related to the death?**

- Yes
- No
- U/K

**i. Was death caused by a medical misadventure?**

- Yes
- No
- U/K

**H9. OTHER KNOWN INJURY CAUSE**

Specify cause, describe in detail:
### 1. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

#### 12. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?

**a. Incident sleep place:**
- Crib
  - If crib, type:
    - Not portable
    - Portable, e.g. Pack ‘n Play
    - Unknown crib type
    - Bassinet
    - Bed side sleeper
    - Baby box
  - Adult bed
  - Waterbed
  - Futon
  - Playpen/other play structure, not a portable crib
  - Couch
  - Chair
  - Floor
  - U/K

**b. Child put to sleep:**
- On back
- On stomach
- On side
- U/K

**c. Child found:**
- On back
- On stomach
- On side
- U/K

**d. Usual sleep place:**
- Crib
  - If crib, type:
    - Not portable
    - Portable, e.g. Pack ‘n Play
    - Unknown crib type
    - Bassinet
    - Bed side sleeper
    - Baby box
  - Adult bed
  - Waterbed
  - Futon
  - Playpen/other play structure, not a portable crib
  - Couch
  - Chair
  - Floor
  - U/K

**e. Usual sleep position:**
- On back
- On stomach
- On side
- U/K

**f. Was there any type of crib, Pack ‘n Play, bassinet, bed side sleeper or baby box in home for child?**
- Yes
- No
- U/K

**g. Child in a new or different environment than usual?**
- Yes
- No
- U/K

**h. Child last placed to sleep with a pacifier?**
- Yes
- No
- U/K

**i. Child wrapped or swaddled in blanket?**
- Yes
- No
- U/K

**j. Child overheated?**
- Yes
- No
- U/K

**k. Child exposed to second hand smoke?**
- Yes
- No
- U/K

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

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

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

**If fully or partially obstructed, what was obstructed?**
- Nose
- Mouth
- Neck

**If fully or partially obstructed, describe obstruction in detail:**
0. Objects in child's sleep environment and relation to airway obstruction:

<table>
<thead>
<tr>
<th>Objects:</th>
<th>Present?</th>
<th>On top</th>
<th>Under</th>
<th>Next</th>
<th>Tangled</th>
<th>obstruct airway?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult(s)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other child(ren)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Animal(s)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mattress</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comforter, quilt,</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitted sheet</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thin blanket/flat</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillow(s)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cushion</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boppy or U shaped</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep positioner</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bumper pads</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crib railing/side</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toy(s)</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other(s), specify:</td>
<td>Yes</td>
<td>No</td>
<td>U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If present, describe position of object:
- If present, did object obstruct airway?

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

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

3. 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? Yes No U/K
- c. Is a recall in place? Yes No U/K
- d. Did product have safety label? Yes No U/K
- e. Was Consumer Product Safety Commission (CPSC) notified? Yes No, go to www.saferproducts.gov to report U/K

4. 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:
- b. Robbery/burglary
- c. Other assault
- d. Arson
- e. Illegal border crossing
- f. Interpersonal violence
- g. Gang conflict
- h. Prostitution
- i. Auto theft
- j. Sexual assault
- k. Drug trade
- l. Witness intimidation
- m. 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?
- Yes/probable
- No, go to next section
- U/K, go to next section

If yes/probable, choose primary reason:
- Child abuse, go to 15b
- Child neglect, go to 15f
- Poor/absent supervision, go to 15h
- Exposure to hazards, go to 15g

#### b. Type of child abuse, check all that apply:
- Abusive head trauma, go to 15c
- Chronic Battered Child Syndrome, go to 15e
- Beating/kicking, go to 15e
- Scalding or burning, go to 15e
- Munchausen Syndrome by Proxy, go to 15e
- Sexual assault, go to 15h
- Other, specify and go to 15h
- U/K, go to 15g

#### c. For abusive head trauma, were there retinal hemorrhages?
- Yes
- No
- U/K

#### d. For abusive head trauma, was the child shaken?
- Yes
- No
- U/K

#### e. Events(s) triggering child abuse, check all that apply:
- None
- Crying
- Toilet training
- Disobedience
- Feeding problems
- Domestic argument
- Other, specify:
- U/K

#### f. Child neglect, check all that apply:
- Failure to provide necessities
  - Food
  - Shelter
  - Other, specify:
- Failure to provide supervision:
- Emotional neglect, specify:
- Abandonment, specify:
- Failure to seek/ follow treatment, specify:
- If yes, was this due to religious or cultural practices?
  - Yes
  - No
  - U/K

#### g. Exposure to hazards:
- Do not include child’s own behavior.
  - Hazard(s) in sleep environment
    - (including sleep position and surface sharing)
    - Fire hazard
  - Unsecured medication/ poison
  - Firearm hazard
  - Motor vehicle hazard
  - Water hazard
  - Other hazard, specify:

#### h. Was poverty a factor?
- Yes
- No
- U/K

### I7. LIFE STRESSORS

Please indicate all stressors that occurred around or affected the decedent and may have contributed to the death.

#### a. Life stressors - Social/economic
- None listed
- Discrimination
- Neighborhood discord
- Money problems
- Housing instability
- Pregnancy
- Racism
- Poverty
- Job problems
- Food insecurity
- Witnessed violence

### J. PERSON RESPONSIBLE (OTHER THAN DECEDED)

1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?
   - Yes/probable
   - No, go to Section K
   - U/K, go to Section 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.

3. Did the team have information about the person(s)?
   - Yes
   - No, go to Section K

4. Is person listed in a previous section?

5. Primary person(s) responsible for action(s):
   Select one for each person responsible.

6. Person's age in years:
   - One
   - Two

7. Person's sex:
   - One
   - Two

8. Person speaks and understands English?
   - One
   - Two

9. Person on active military duty?
   - One
   - Two
<table>
<thead>
<tr>
<th>Question</th>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Person(s) have history of substance abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>U/K</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. Person(s) have history of child maltreatment as victim?</td>
<td></td>
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<tr>
<td>Yes</td>
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<tr>
<td>Cocaine</td>
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<td>12. Person(s) have history of child maltreatment as a perpetrator?</td>
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<td>If mental health/substance abuse, was person receiving mental health services?</td>
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<td>Yes</td>
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<td>13. Person(s) have disability or chronic illness?</td>
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<td>14. Person(s) have prior child deaths?</td>
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<tr>
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<td>If yes, check all that apply:</td>
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<td>Child abuse #</td>
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<td>15. Person(s) have history of intimate partner violence?</td>
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<td>Yes</td>
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<tr>
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<tr>
<td>U/K</td>
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<tr>
<td>If yes, check all that apply:</td>
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<tr>
<td>Yes, as victim</td>
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<tr>
<td>Yes, as perpetrator</td>
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<td>16. Person(s) have delinquent/criminal history?</td>
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<td>Yes</td>
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<tr>
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<tr>
<td>If mental health/substance abuse, was person receiving mental health services?</td>
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<td>Yes</td>
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<tr>
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<tr>
<td>17. At the time of the incident, was the person asleep?</td>
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<tr>
<td>Yes</td>
<td>☐</td>
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<tr>
<td>U/K</td>
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<td>If yes, select the most appropriate description of the person's sleeping period at incident:</td>
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<td>Night time sleep</td>
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<tr>
<td>Day time nap, describe:</td>
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<tr>
<td>Day time sleep (for example, person is night shift worker), describe:</td>
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<tr>
<td>Other, describe:</td>
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<tr>
<td>18. At time of incident was person impaired?</td>
<td></td>
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<td>Yes</td>
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<tr>
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<tr>
<td>U/K</td>
<td>☐</td>
<td>☐</td>
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<td>If yes, check all that apply:</td>
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<td>Drug impaired, specify:</td>
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<td>Alcohol impaired</td>
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<td>Absent</td>
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<td>Impaired by illness, specify:</td>
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<td>Impaired by disability, specify:</td>
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<tr>
<td>Other, specify:</td>
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<td>19. Person(s) have, check all that apply:</td>
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<td>Prior history of similar acts</td>
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<td>Prior arrests</td>
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<tr>
<td>Prior convictions</td>
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<td>20. Legal outcomes in this death, check all that apply:</td>
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<tr>
<td>No charges filed</td>
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<tr>
<td>Charges pending</td>
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<td>☐</td>
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<tr>
<td>Charges dismissed</td>
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<td>☐</td>
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<tr>
<td>Confession</td>
<td>☐</td>
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<tr>
<td>Plead, specify:</td>
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<td>☐</td>
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<tr>
<td>Not guilty verdict</td>
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<td>Guilty verdict, specify:</td>
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<td>☐</td>
</tr>
<tr>
<td>Tort charges, specify:</td>
<td>☐</td>
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</tbody>
</table>
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?  
   Yes No U/K

   If yes, select one option per row: Referred for service Review led to Referral needed, before review referral not available N/A U/K

   - Bereavement counseling
   - Debriefing for professionals
   - Economic support
   - Funeral arrangements
   - Emergency shelter
   - Mental health services
   - Foster care
   - Health services
   - Legal services
   - Genetic counseling
   - Home visiting
   - Substance abuse
   - Other, specify:

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?  
      Yes No U/K

      If yes, select all that apply and describe:

      - Child welfare Describe:
      - Law enforcement Describe:
      - Public health Describe:
      - Coroner/medical examiner Describe:
      - Courts Describe:
      - Health care systems Describe:
      - Education Describe:
      - Mental health Describe:
      - EMS Describe:
      - Substance abuse Describe:
      - Other, specify: Describe:

   5. Could the death have been prevented?  
      Yes, probably No, probably not 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?  
      N/A Yes No

   4. Agencies and individuals at review meeting, check all that apply:

      - Medical examiner/coroner/pathologist
      - CPS
      - Fire
      - Indian Health Services/
      - Military
      - Death investigator
      - Other social services
      - EMS
      - Tribal Health
      - Domestic violence
      - Law enforcement
      - Physician
      - Faith based organization
      - Home visiting
      - Others, list:
      - Prosecutor/district attorney
      - Nurse
      - Education
      - Healthy Start
      - Court
      - Public health
      - Hospital
      - Mental health
      - Child advocate
      - HMO/managed care
      - Other health care
      - Substance abuse
5. Were the following data sources available at the review meeting?

- CDC's SUIDI Reporting Form
- Jurisdictional equivalent of the CDC SUIDI Reporting Form
- Birth certificate - full form
- Death certificate
- Child's medical records or clinical history, including vaccinations
- Biological mother's obstetric and prenatal information
- Newborn screening results
- Law enforcement records
- Social service records
- Child protection agency records
- EMS run sheet
- Hospital records
- Autopsy/pathology reports
- Home visiting
- Mental health records
- School records
- Substance abuse treatment records

6. Did any of the following factors reduce meeting effectiveness. check all that apply:

- None
- Confidentiality issues among members prevented full exchange of information
- HIPAA regulations prevented access to or exchange of information
- Inadequate investigation precluded having enough information for review
- Team members did not bring adequate information to the meeting
- Necessary team members were absent
- Meeting was held too soon after death
- Meeting was held too long after death
- Records or information were needed from another locality in-state
- Records or information were needed from another state
- Team disagreement on circumstances
- Other factors, specify:

7. Review meeting outcomes, check all that apply:

- Review led to additional investigation
- Team disagreed with official manner of death. What did team believe manner should be?
- Team disagreed with official cause of death. What did team believe cause should be?
- Because of the review, the official cause or manner of death was changed
- Review led to the delivery of services
- Review led to changes in agency policies or practices
- Review led to prevention initiatives being implemented

0. 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 MPHICFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.
<table>
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<tr>
<th>O2.</th>
<th>Pre-/Inter-/Post-conception Care</th>
<th>3.</th>
<th>Family Planning</th>
<th>8.</th>
<th>Environment</th>
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<tr>
<td>Y N U Preconception care</td>
<td>P C Intended pregnancy</td>
<td>P C Unsafe neighborhood</td>
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<td>Y N U Postpartum visit kept</td>
<td>P C Unintended pregnancy</td>
<td>P C Substandard housing</td>
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<td>Y N U Pregnancy planning/BC education</td>
<td>P C Unwanted pregnancy</td>
<td>P C Overcrowding</td>
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<td>□ Before □ During □ After</td>
<td>P C No birth control</td>
<td>P C Second-hand smoke</td>
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<td>Y N U Dental/oral care</td>
<td>P C Failed contraceptive</td>
<td>P C Little/no breastfeeding</td>
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<td>□ Before □ During □ After</td>
<td>P C Lack of knowledge: methods</td>
<td>P C Improper formula prep/feeding</td>
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<td>Y N U Chronic disease control education</td>
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<td>P C Improper/no car seat use</td>
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<td>□ Before □ During □ After</td>
<td>P C Other, specify:</td>
<td>P C Unsafe sleep location</td>
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<td>Y N U Weight mgmt/dietitian</td>
<td>□ Before □ During □ After</td>
<td>P C Objects in sleep environment</td>
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<td>Y N U Bereavement referral</td>
<td>P C Positive drug test</td>
<td>P C Infant overheating</td>
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<td>P C Early teen (17 and under) pregnancy</td>
<td>P C No drug test</td>
<td>P C Suffocation/strangulation</td>
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<td>P C Late teen (18 &amp; 19) pregnancy</td>
<td>P C Tobacco use: hx, not current</td>
<td>P C Abuse head trauma</td>
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<td>P C Pregnancy &gt;35 yrs</td>
<td>P C Tobacco use: current</td>
<td>P C General trauma</td>
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<td>P C Cord problem</td>
<td>P C Alcohol use: hx, not current</td>
<td>P C Other, specify:</td>
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<td>P C Placental abruption</td>
<td>P C Alcohol use: current</td>
<td>10. Social Support</td>
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<td>P C Placenta Previa</td>
<td>P C Illicit drug use: hx, not current</td>
<td>P C Lack of family support</td>
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<td>P C Use of un-pres meds: type:</td>
<td>P C Lack of partner/FOB support</td>
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<td>P C Previous abnormal PAP</td>
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<td>Prenatal Care/Delivery</td>
<td>11. Partner/Father of Baby/Caregiver</td>
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<td>P C Infection: BV</td>
<td>P C Standard of care not met</td>
<td>P C Employment ○ Yes ○ No</td>
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<td>P C Infection: Group B Strep</td>
<td>P C No prenatal care</td>
<td>P C Hx of mental illness</td>
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<td>P C Infection: Urinary tract infection</td>
<td>P C Late entry to prenatal care</td>
<td>P C Substance or tobacco</td>
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<td>P C STI - __________________</td>
<td>P C Lack of progesterone therapy</td>
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<td>P C Lack of referrals</td>
<td>P C Substance or tobacco</td>
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<td>P C Multiple gestation #</td>
<td>P C Missed appointments</td>
<td>use/abuse: current specify:</td>
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<td>P C Mother’s weight BMI:</td>
<td>P C Multiple providers/sites</td>
<td>P C Other, specify:</td>
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<td>P C Insufficient/excess weight gain</td>
<td>P C Lack of dental assessment</td>
<td>12. Family Transition</td>
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<td>P C Poor nutrition</td>
<td>P C Lack of dental care</td>
<td>P C Frequent/recent moves</td>
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<td>P C Living in shelter/homeless</td>
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<td>P C Preeclampsia</td>
<td>P C Other, specify:</td>
<td>P C Concern re: citizenship</td>
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<td>P C Non-viable fetus</td>
<td>P C Hx of mental illness (mom)</td>
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<td>P C Pregnancy &lt;18 m apart</td>
<td>P C LBW (&lt;2500 grams)</td>
<td>P C Depression/anxiety/mental illness</td>
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<td>P C PROM</td>
<td>P C LVLB (&lt;1500 grams)</td>
<td>during pregnancy</td>
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<td>P C PPROM</td>
<td>P C ELBW (&lt;750 grams)</td>
<td>P C Depression/anxiety/mental illness</td>
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<td>P C Prolonged Rupture of Membrane</td>
<td>P C Intrauterine Growth Restriction</td>
<td>in postpartum period</td>
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<td>P C Pre-existing dental/oral issues</td>
<td>P C Congenital anomaly</td>
<td>P C Multiple stresses</td>
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<tr>
<td>P C Oligo-/Polyhydramnios</td>
<td>P C Prematurity</td>
<td>P C Social chaos</td>
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<tr>
<td>P C Previous SABs or miscarriages#</td>
<td>P C Infection/sepsis</td>
<td>P C Employment ○ Yes ○ No</td>
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<tr>
<td>P C Previous Therapeutic ab # /Vol ab #</td>
<td>P C Failure to thrive</td>
<td>P C Concern about enough money</td>
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<tr>
<td>P C Previous fetal loss #</td>
<td>P C Birth injury</td>
<td>11. Partner/Father of Baby/Caregiver</td>
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<tr>
<td>P C Previous infant loss # ______</td>
<td>P C Other, specify:</td>
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<td>P C Previous LBW delivery</td>
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<td>Pediatric Care</td>
<td>12. Family Transition</td>
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<td>P C Previous preterm delivery</td>
<td>P C Standard of care not met</td>
<td>P C Frequent/recent moves</td>
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<td>P C VBAC this pregnancy</td>
<td>P C Inadequate assessment</td>
<td>P C Living in shelter/homeless</td>
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<td>P C Previous C-Section: #</td>
<td>P C No pediatric care</td>
<td>P C Concern re: citizenship</td>
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<td>P C C-Section this pregnancy</td>
<td>P C Lack of referrals</td>
<td>P C Divorce/separation</td>
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<td>P C Previous ectopic pregnancy</td>
<td>P C Missed aptmnt/immunizations</td>
<td>P C Multiple partners</td>
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<tr>
<td>P C First pregnancy &lt;18 yrs old</td>
<td>P C Multiple providers/sites</td>
<td>P C Mom: prison/parole/probation</td>
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<td>P C &gt;4 Live births</td>
<td>P C Inappropriate use of ER</td>
<td>P C FOB: prison/parole/probation</td>
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<td>P C Assist reprod tech:</td>
<td>P C Other, specify:</td>
<td>P C Major illness/death in family</td>
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<td>Environment</td>
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<td>P C Unsafe neighborhood</td>
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<td>13. Mental Health/Stress</td>
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<td>P C Substandard housing</td>
<td>P C Hx of mental illness (mom)</td>
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<td>P C Overcrowding</td>
<td>P C Depression/anxiety/mental illness</td>
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<td>P C Second-hand smoke</td>
<td>during pregnancy</td>
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<td>P C Little/no breastfeeding</td>
<td>P C Depression/anxiety/mental illness in postpartum period</td>
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<td>P C Improper formula prep/feeding</td>
<td>P C Multiple stresses</td>
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<td>P C Improper/no car seat use</td>
<td>P C Social chaos</td>
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<td>P C Unsafe sleep location</td>
<td>P C Employment ○ Yes ○ No</td>
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<td>P C Objects in sleep environment</td>
<td>P C Concern about enough money</td>
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<td>13. Mental Health/Stress (continued)</td>
<td>17. Services Provided</td>
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<td>P C Work/employment problems</td>
<td>P C Inadequate information</td>
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<td>P C Child(ren) with special needs</td>
<td>P C Lack of WIC (eligible)</td>
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<td>P C Problems with family/relatives</td>
<td>P C Mother/child not eligible</td>
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<td>P C Lack of grief support</td>
<td>P C Lack of Home Visiting (eligible)</td>
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<td>P C Other, specify:</td>
<td>P C Poor provider to provider communication</td>
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<td><strong>14. Family Violence/Neglect</strong></td>
<td>P C Poor provider to patient communication</td>
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<td>P C History of abuse (mom), specify:</td>
<td>P C Client dissatisfaction</td>
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<td>P C Current abuse (mom), specify:</td>
<td>P C Dissatisfaction – support services</td>
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<td>P C History of abuse (FOB), specify:</td>
<td>P C Lack of child care</td>
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<td>P C Current abuse (FOB), specify:</td>
<td>P C Other, specify:</td>
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<td>P C Hx child abuse: other child</td>
<td>P C Poor provider to patient communication</td>
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<td>P C Police reports</td>
<td>P C Other, specify:</td>
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P. FORM COMPLETED BY:

Person: Email:
Title: Date completed:
Agency: Data entry completed for this case? [ ]
Phone: For State Program Use Only:

Data entry completed for this case? [ ]

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 info@ncfrp.org 1-800-656-2434 Facebook and Twitter: NationalCFRP