

**CASE NUMBER**

_____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive	Death Certificate Number: Birth Certificate Number: ME/Coroner Number: Date CDRT Notified of Death:
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**A. CHILD INFORMATION**

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K																													
2. Date of birth: <input type="checkbox"/> U/K  mm / dd / yyyy	3. Date of death: <input type="checkbox"/> U/K  mm / dd / yyyy	4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K	5. Race, check all that apply: <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander, specify: <input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> Alaskan Native, Tribe: _____	6. Hispanic or Latino origin? <input type="checkbox"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																								
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____		9. Type of residence: <input type="checkbox"/> U/K <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: _____ <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K		10. New residence in past 30 days? <input type="checkbox"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																									
11. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		12. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		13. Number of other children living with child: _____ <input type="checkbox"/> U/K																									
14. Child's weight: <input type="checkbox"/> U/K <input type="radio"/> Pounds/ounces _____ <input type="radio"/> Grams/kilograms _____		15. Child's height: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ <input type="radio"/> Cm _____		16. Highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: _____ <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12																									
17. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K		18. Did child have problems in school? <input type="checkbox"/> U/K <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> U/K <input type="checkbox"/> Other, specify: _____		19. Child's health insurance, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K																									
20. Child had disability or chronic illness? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical/orthopedic, specify: _____ <input type="checkbox"/> Mental health/substance abuse, specify: _____ <input type="checkbox"/> Cognitive/intellectual, specify: _____ <input type="checkbox"/> Sensory, specify: _____ <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		21. Child's mental health (MH): Child had received prior MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child was receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child on medications for MH illness? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Issues prevented child from receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify: _____		22. Child had history of substance abuse? <input type="checkbox"/> U/K <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> U/K <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs																									
23. Child had history of child maltreatment? If yes, check all that apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> </tr> <tr> <td><input type="radio"/> N/A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Physical</td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neglect</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sexual</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Emotional/psychological</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table> If yes, how was history identified: <input type="radio"/> Through CPS    _____ # CPS referrals <input type="radio"/> Other sources    _____ # Substantiations		<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>	<input type="radio"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neglect	<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual	<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional/psychological		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K	24. Was there an open CPS case with child at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		27. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K																										
25. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		26. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K																											
28. Child had delinquent or criminal history? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Robbery <input type="checkbox"/> U/K <input type="checkbox"/> Drugs <input type="checkbox"/> U/K		29. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		32. If child over age 12, what was child's gender identity? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																									
30. Child acutely ill during the two weeks before death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		31. Was any parent a first generation immigrant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, country of origin: _____		33. If child over age 12, what was child's sexual orientation? <input type="radio"/> Heterosexual <input type="radio"/> Lesbian <input type="radio"/> Questioning <input type="radio"/> Gay <input type="radio"/> Bisexual <input type="radio"/> U/K																									

**COMPLETE FOR ALL INFANTS UNDER ONE YEAR**

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____/____	36. Multiple birth? <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K	37. Including the deceased infant, how many pregnancies did the birth mother have? # ____ <input type="checkbox"/> U/K	38. Including the deceased infant, how many live births did the birth mother have? # ____ <input type="checkbox"/> U/K
39. Not including the deceased infant, number of children birth mother still has living? # ____ <input type="checkbox"/> U/K	40. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, number of prenatal visits: # ____ <input type="checkbox"/> U/K If yes, month of first prenatal visit: Specify 1-9 ____ <input type="checkbox"/> U/K			
41. During pregnancy, did mother (check all that apply): Yes No U/K <input type="radio"/> <input type="radio"/> <input type="radio"/> Have medical complications/infections? <input type="radio"/> <input type="radio"/> <input type="radio"/> Experience intimate partner violence? <input type="radio"/> <input type="radio"/> <input type="radio"/> Use illicit drugs? <input type="checkbox"/> Infant born drug exposed? <input type="radio"/> <input type="radio"/> <input type="radio"/> Misuse OTC or prescription drugs? <input type="radio"/> <input type="radio"/> <input type="radio"/> Have heavy alcohol use? <input type="checkbox"/> Infant born with fetal alcohol effects or syndrome?		If yes, medical complications/infections, check all that apply: <input type="checkbox"/> Acute/chronic lung disease <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Previous infant 4000+ grams <input type="checkbox"/> Anemia <input type="checkbox"/> High MSAFP <input type="checkbox"/> Previous infant preterm/ small for gestation <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Hydramnios/oligohydramnios <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> PROM <input type="checkbox"/> Chronic hypertension <input type="checkbox"/> Low MSAFP <input type="checkbox"/> Renal disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other infectious disease <input type="checkbox"/> Rh sensitization <input type="checkbox"/> Eclampsia <input type="checkbox"/> Pregnancy-related hypertension <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Genital herpes <input type="checkbox"/> Preterm labor <input type="checkbox"/> Other, specify:		
42. Were there access or compliance issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Cultural differences <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Lack of child care <input type="checkbox"/> Intimate partner would not allow care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Language barriers <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Other, specify: <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Referrals not made <input type="checkbox"/> Services not available <input type="checkbox"/> U/K <input type="checkbox"/> No phone <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Distrust of health care system				
43. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, ____ Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> U/K quantity	44. Did mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	Trimester 1 Trimester 2 Trimester 3 If yes, _____ Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> U/K quantity		
45. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	46. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:	47. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was abnormality a fatty acid oxidation error, such as MCAD? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: If other abnormalities, describe:		
48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply): <input type="checkbox"/> Infection <input type="checkbox"/> Cyanosis <input type="checkbox"/> Allergies <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Apnea <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Other, specify:		49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Apnea <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Choking <input type="checkbox"/> Cyanosis <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Diarrhea <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Stool changes <input type="checkbox"/> Other, specify: <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Difficulty breathing		
50. In the 72 hours prior to death, was the infant injured? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe cause and injuries:	51. In the 72 hours prior to death, was the infant given any vaccines? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name(s) of vaccines:	52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name and last dose given:	53. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> Other, specify: <input type="checkbox"/> Formula, type: _____ <input type="checkbox"/> Baby food, type: _____ <input type="checkbox"/> Cereal, type: _____ <input type="checkbox"/> U/K	

**B. PRIMARY CAREGIVER(S) INFORMATION**

1. Primary caregiver(s): Select only one each in columns one and two. <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table> </td> <td style="width:50%; vertical-align: top;"> <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td><input type="checkbox"/> <input type="checkbox"/> U/K</td> </tr> </table>                 3. 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Caregiver(s) employment status: <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Employed</td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> U/K	5. 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6. Caregiver(s) education: <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> &lt; High school</td> <td><input type="radio"/> High school</td> </tr> <tr> <td><input type="radio"/> College</td> <td><input type="radio"/> Post graduate</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> < High school	<input type="radio"/> High school	<input type="radio"/> College	<input type="radio"/> Post graduate	<input type="radio"/> U/K		7. Do caregiver(s) speak English? <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If no, language spoken:	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		8. Caregiver(s) on active military duty? <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If yes, specify branch:	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		9. Caregiver(s) receive social services in the past twelve months? <table style="width:100%;"> <tr> <td style="width:50%;"><u>One</u></td> <td style="width:50%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/> WIC</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="checkbox"/> TANF</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Food stamps</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td></td> <td><input type="checkbox"/> U/K</td> </tr> </table> If yes, check all that apply	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="checkbox"/> WIC	<input type="radio"/> No	<input type="checkbox"/> TANF	<input type="radio"/> U/K	<input type="checkbox"/> Medicaid		<input type="checkbox"/> Food stamps		<input type="checkbox"/> Other, specify:		<input type="checkbox"/> U/K													
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	<input type="checkbox"/> Food stamps																																																	
	<input type="checkbox"/> Other, specify:																																																	
	<input type="checkbox"/> U/K																																																	

<p><b>10. Caregiver(s) have substance abuse history?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/>    <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/>    <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p><b>11. Caregiver(s) ever victim of child maltreatment?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ever in foster care or adopted</p>	<p><b>12. Caregiver(s) ever perpetrator of maltreatment?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Children ever removed</p>	<p><b>13. Caregiver(s) have disability or chronic illness?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>If mental illness, was caregiver receiving MH services?</p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>
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<p><b>14. Caregiver(s) have prior child deaths?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u>    <u>Two</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p><b>15. Caregiver(s) have history of intimate partner violence?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/>    <input type="checkbox"/> No</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p><b>16. Caregiver(s) have delinquent/criminal history?</b></p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/>    <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/>    <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>
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**C. SUPERVISOR INFORMATION**

<p><b>1. Did child have supervision at time of incident leading to death?</b></p> <p><input type="radio"/> Yes, answer 2-15</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sect. D</p> <p><input type="radio"/> No, but needed, answer 3-15</p> <p><input type="radio"/> Unable to determine, try to answer 3-15</p>	<p><b>2. How long before incident did supervisor last see child? Select one:</b></p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____    <input type="radio"/> Days _____</p> <p><input type="radio"/> Hours _____    <input type="radio"/> U/K</p>	<p><b>3. Is person a primary caregiver as listed in previous section?</b></p> <p><input type="radio"/> Yes, caregiver one, go to 15</p> <p><input type="radio"/> Yes, caregiver two, go to 15</p> <p><input type="radio"/> No</p>
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**4. Primary person responsible for supervision? Select only one:**

Biological parent     Foster parent     Grandparent     Friend     Institutional staff, go to 15     Other, specify:  
 Adoptive parent     Mother's partner     Sibling     Acquaintance     Babysitter  
 Stepparent     Father's partner     Other relative     Hospital staff, go to 15     Licensed child care worker     U/K

<p><b>5. Supervisor's age in years:</b></p> <p>_____    <input type="checkbox"/> U/K</p>	<p><b>6. Supervisor's sex:</b></p> <p><input type="radio"/> Male    <input type="radio"/> Female    <input type="radio"/> U/K</p>	<p><b>7. Does supervisor speak English?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p><b>8. Supervisor on active military duty?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
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<p><b>9. Supervisor has substance abuse history?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p><b>10. Supervisor has history of child maltreatment?</b></p> <p><u>As Victim</u>    <u>As Perpetrator</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ever in foster care/adopted</p> <p><input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> Children ever removed</p>	<p><b>11. Supervisor has disability or chronic illness?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p><b>12. Supervisor has prior child deaths?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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13. Supervisor has history of intimate partner violence? <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	14. Supervisor has delinquent or criminal history? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Drugs <input type="checkbox"/> U/K <input type="checkbox"/> Robbery <input type="checkbox"/> Other, specify: _____	15. At time of incident was supervisor impaired? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Drug impaired, specify: _____ <input type="checkbox"/> Absent <input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Impaired by illness, specify: _____ <input type="checkbox"/> Asleep <input type="checkbox"/> Impaired by disability, specify: _____ <input type="checkbox"/> Distracted <input type="checkbox"/> Other, specify: _____
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**D. INCIDENT INFORMATION**

1. Date of incident event: <input type="radio"/> Same as date of death <input type="radio"/> If different than date of death: ____/____/____ <input type="radio"/> U/K (mm/dd/yyyy)	2. Approximate time of day that incident occurred? <input type="radio"/> AM <input type="radio"/> PM <input type="radio"/> U/K Hour, specify 1-12 ____	3. Interval between incident and death: <input type="checkbox"/> U/K <input type="checkbox"/> Minutes ____ <input type="checkbox"/> Weeks ____ <input type="checkbox"/> Hours ____ <input type="checkbox"/> Months ____ <input type="checkbox"/> Days ____ <input type="checkbox"/> Years ____
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4. Place of incident, check all that apply: <input type="checkbox"/> Child's home <input type="checkbox"/> Licensed group home <input type="checkbox"/> School <input type="checkbox"/> Sidewalk <input type="checkbox"/> Sports area <input type="checkbox"/> Relative's home <input type="checkbox"/> Licensed child care center <input type="checkbox"/> Place of work <input type="checkbox"/> Roadway <input type="checkbox"/> Other recreation area <input type="checkbox"/> Friend's home <input type="checkbox"/> Licensed child care home <input type="checkbox"/> Indian reservation <input type="checkbox"/> Driveway <input type="checkbox"/> Hospital <input type="checkbox"/> Licensed foster care home <input type="checkbox"/> Unlicensed child care home <input type="checkbox"/> Military installation <input type="checkbox"/> Other parking area <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Relative foster care home <input type="checkbox"/> Farm <input type="checkbox"/> Jail/detention facility <input type="checkbox"/> State or county park <input type="checkbox"/> U/K	5. Type of area: <input type="radio"/> Urban <input type="radio"/> Suburban <input type="radio"/> Rural <input type="radio"/> Frontier <input type="radio"/> U/K
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6. Incident state:	7. Incident county:	8. Death state:	9. Death county:	10. Was the incident witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> UK If yes, by whom? <input type="checkbox"/> Parent/relative <input type="checkbox"/> Health care professional, if death occurred in a hospital setting <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Stranger <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Other, specify: _____
11. Was 911 or local emergency called? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				

12. Was resuscitation attempted? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, by whom? <input type="checkbox"/> EMS <input type="checkbox"/> Stranger <input type="checkbox"/> Parent/relative <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Health care professional, if death occurred in a hospital setting			If yes, type of resuscitation: <input type="checkbox"/> CPR <input type="checkbox"/> Automated External Defibrillator (AED) If no AED, was AED available/accessible? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If AED, was shock administered? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many shocks were administered? _____ <input type="checkbox"/> Rescue medications, specify type: _____ <input type="checkbox"/> Other, specify: _____	If yes, was a rhythm recorded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, what was the rhythm? _____
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13. At time of incident leading to death, had child used drugs or alcohol? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	14. Child's activity at time of incident, check all that apply: <input type="checkbox"/> Sleeping <input type="checkbox"/> Working <input type="checkbox"/> Driving/vehicle occupant <input type="checkbox"/> U/K <input type="checkbox"/> Playing <input type="checkbox"/> Eating <input type="checkbox"/> Other, specify: _____	15. Total number of deaths at incident event: <input type="radio"/> U/K ____ Children, ages 0-18 ____ Adults
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**E. INVESTIGATION INFORMATION**

1. Death referred to: <input type="radio"/> Medical examiner <input type="radio"/> Coroner <input type="radio"/> Not referred <input type="radio"/> U/K	2. Person declaring official cause and manner of death: <input type="radio"/> Medical examiner <input type="radio"/> Mortician <input type="radio"/> Coroner <input type="radio"/> Other, specify: _____ <input type="radio"/> Hospital physician <input type="radio"/> U/K <input type="radio"/> Other physician	3. Autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, conducted by: <input type="radio"/> Forensic pathologist <input type="radio"/> Other physician <input type="radio"/> Pediatric pathologist <input type="radio"/> Other, specify: _____ <input type="radio"/> General pathologist <input type="radio"/> Unknown pathologist <input type="radio"/> U/K If no, why not (e.g. parent or caregiver objected)? _____
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If autopsy performed, was a specialist consulted during autopsy (cardiac, neurology, etc.)?  Yes  No  U/K If yes, specify specialist: \_\_\_\_\_

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy: <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Y N U/K Abnormal?</th> <th style="text-align: left;">Y N U/K Abnormal?</th> <th style="text-align: left;">Y N U/K Abnormal?</th> </tr> <tr> <td> <b>Imaging:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> X-ray - single  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> X-ray - multiple views  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> X-ray - complete skeletal series  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> CT scan  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> MRI  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Photography of the brain  <b>External Exam:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Exam of general appearance  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Head circumference  <b>Gross Examination of:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Body cavities  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Brain  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Endocrine organs  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Gastrointestinal tract  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Heart  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Kidneys  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Liver           </td> <td> <b>Gross Examination continued:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Lungs  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Neck structures  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Pancreas  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Spleen  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Thymus  <b>In situ exam with removal &amp; dissection of:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Brain  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Endocrine organs  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Gastrointestinal tract  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Heart  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Kidneys  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Liver  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Lungs  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Neck structures  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Pancreas  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Spleen  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Thymus           </td> <td> <b>Weights of the:</b>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Brain  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Heart  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Kidneys  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Liver  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Lungs  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Neck structures  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Pancreas  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Spleen  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Thymus           </td> </tr> </table>	Y N U/K Abnormal?	Y N U/K Abnormal?	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4. Continued: Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Y	N	U/K	Abnormal?	Y	N	U/K	Abnormal?	Y	N	U/K	Abnormal?						
<b>Sampled tissue of:</b>				<b>Microscopic/Histological exam of:</b>				<b>Additional Testing:</b>									
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Airway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Airway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Cultures for infectious disease			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Bone or costochondral tissue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Bone or costochondral tissue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Microbiology			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Brain or meninges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Brain or meninges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Postmortem metabolic screen			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Endocrine organs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Endocrine organs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Vitreous testing as an adjunct to other investigation results			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Gastrointestinal tract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Gastrointestinal tract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Genetic testing			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Heart	<b>Toxicology:</b>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Toxicology If yes, check all that apply:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Kidneys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Kidneys	<input type="checkbox"/>	Negative	<input type="checkbox"/>	Opiates				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Liver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Too high Rx drug, specify:				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Lungs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	Too high OTC drug, specify:				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Neck structures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Neck structures	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Other, specify:				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Pancreas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Pancreas	<input type="checkbox"/>	Methamphetamine	<input type="checkbox"/>	U/K				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Spleen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Spleen								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Thymus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Thymus								

5. Was the child's medical history reviewed as part of the autopsy?  Yes  No  U/K  
 If yes, did this include:  
 Review of the newborn metabolic screen results?  Yes  No  U/K  Not Performed  
 Review of neonatal CCHD screen results?  Yes  No  U/K  Not Performed

6. Describe any abnormalities checked in E4 or E5 or other significant findings noted in the autopsy:

7. Was there agreement between the cause of death listed on the pathology report and on the death certificate?  Yes  No  U/K  
 If no, describe the differences:

8. Was a death scene investigation performed?  Yes  No  U/K  
 If yes, which of the following death scene investigation components were completed?

Yes	No	U/K		Yes	No	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?

9. Agencies that conducted a scene investigation, check all that apply:

<input type="checkbox"/>	Medical examiner	<input type="checkbox"/>	Fire investigator
<input type="checkbox"/>	Coroner	<input type="checkbox"/>	EMS
<input type="checkbox"/>	ME investigator	<input type="checkbox"/>	Child Protective Services
<input type="checkbox"/>	Coroner investigator	<input type="checkbox"/>	Other, specify:
<input type="checkbox"/>	Law enforcement	<input type="checkbox"/>	U/K

10. Was a CPS record check conducted as a result of death?  Yes  No  U/K

11. Did any investigation find evidence of prior abuse? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, from what source? Check all that apply: <input type="checkbox"/> From x-rays <input type="checkbox"/> U/K <input type="checkbox"/> From autopsy <input type="checkbox"/> From CPS review <input type="checkbox"/> From law enforcement	12. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated If yes, services or actions resulting, check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Court-ordered services provided <input type="checkbox"/> Voluntary out of home placement <input type="checkbox"/> U/K <input type="checkbox"/> Court-ordered out of home placement <input type="checkbox"/> Children removed <input type="checkbox"/> Parental rights terminated	13. If death occurred in licensed setting (see D4), indicate action taken: <input type="radio"/> No action <input type="radio"/> License suspended <input type="radio"/> License revoked <input type="radio"/> Investigation ongoing <input type="radio"/> Other, specify: <input type="radio"/> U/K
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**F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH**

1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: \_\_\_\_\_  U/K

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

Immediate cause (final disease or condition resulting in death):

a. \_\_\_\_\_

Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in F2 exactly as written on the death certificate: \_\_\_\_\_  U/K

4. If injury, describe how injury occurred exactly as written on the death certificate: \_\_\_\_\_  U/K

<p>5. Official manner of death from the death certificate:</p> <p><input type="radio"/> Natural</p> <p><input type="radio"/> Accident</p> <p><input type="radio"/> Suicide</p> <p><input type="radio"/> Homicide</p> <p><input type="radio"/> Undetermined</p> <p><input type="radio"/> Pending</p> <p><input type="radio"/> U/K</p> <hr/> <p>If Homicide: <u>Yes</u></p> <p>Child abuse? <input type="checkbox"/></p> <p>Child neglect? <input type="checkbox"/></p> <p>Complete Section I, Acts of Omission or Commission</p> <hr/> <p>If Suicide: Complete Section I, Acts of Omission or Commission</p>	<p>6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.</p> <p><input type="radio"/> From an injury (external cause). Select one and answer F4:</p> <p><input type="radio"/> Motor vehicle and other transport, go to G1</p> <p><input type="radio"/> Fire, burn, or electrocution, go to G2</p> <p><input type="radio"/> Drowning, go to G3</p> <p><input type="radio"/> Asphyxia, go to G4</p> <p><input type="radio"/> Weapon, including body part, go to G5</p> <p><input type="radio"/> Animal bite or attack, go to G6</p> <p><input type="radio"/> Fall or crush, go to G7</p> <p><input type="radio"/> Poisoning, overdose or acute intoxication, go to G8</p> <p><input type="radio"/> Exposure, go to G9</p> <p><input type="radio"/> Undetermined, go to H1</p> <p><input type="radio"/> Other cause, go to G11</p> <p><input type="radio"/> U/K, go to H1</p> <p><input type="radio"/> From a medical cause. Select one:</p> <p><input type="radio"/> Asthma, go to G10</p> <p><input type="radio"/> Cancer, specify and go to G10</p> <p><input type="radio"/> Cardiovascular, specify and go to G10</p> <p><input type="radio"/> Congenital anomaly, specify and go to G10</p> <p><input type="radio"/> Diabetes, go to G10</p> <p><input type="radio"/> HIV/AIDS, go to G10</p> <p><input type="radio"/> Influenza, go to G10</p> <p><input type="radio"/> Low birth weight, go to G10</p> <p><input type="radio"/> Malnutrition/dehydration, go to G10</p> <p><input type="radio"/> Neurological/seizure disorder, go to G10</p> <p><input type="radio"/> Pneumonia, specify and go to G10</p> <p><input type="radio"/> Prematurity, go to G10</p> <p><input type="radio"/> SIDS, go to G10</p> <p><input type="radio"/> Other infection, specify and go to G10</p> <p><input type="radio"/> Other perinatal condition, specify and go to G10</p> <p><input type="radio"/> Other medical condition, specify and go to G10</p> <p><input type="radio"/> Undetermined, go to G10</p> <p><input type="radio"/> U/K, go to G10</p> <p><input type="radio"/> Undetermined if injury or medical cause. go to H1</p> <p><input type="radio"/> U/K go to H1</p>
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**G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE**

**1. MOTOR VEHICLE AND OTHER TRANSPORT**

<p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <table style="width:100%;"> <tr> <th style="text-align: left;"><u>Child's</u></th> <th style="text-align: left;"><u>Other primary vehicle</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> None</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Car</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Van</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Sport utility vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Truck</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Semi/tractor trailer</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> RV</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> School bus</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other bus</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Motorcycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Tractor</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other farm vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> All terrain vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Snowmobile</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Bicycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Train</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Subway</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Trolley</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other, specify:</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> U/K</td></tr> </table>	<u>Child's</u>	<u>Other primary vehicle</u>	<input type="radio"/>	<input type="radio"/> None	<input type="radio"/>	<input type="radio"/> Car	<input type="radio"/>	<input type="radio"/> Van	<input type="radio"/>	<input type="radio"/> Sport utility vehicle	<input type="radio"/>	<input type="radio"/> Truck	<input type="radio"/>	<input type="radio"/> Semi/tractor trailer	<input type="radio"/>	<input type="radio"/> RV	<input type="radio"/>	<input type="radio"/> School bus	<input type="radio"/>	<input type="radio"/> Other bus	<input type="radio"/>	<input type="radio"/> Motorcycle	<input type="radio"/>	<input type="radio"/> Tractor	<input type="radio"/>	<input type="radio"/> Other farm vehicle	<input type="radio"/>	<input type="radio"/> All terrain vehicle	<input type="radio"/>	<input type="radio"/> Snowmobile	<input type="radio"/>	<input type="radio"/> Bicycle	<input type="radio"/>	<input type="radio"/> Train	<input type="radio"/>	<input type="radio"/> Subway	<input type="radio"/>	<input type="radio"/> Trolley	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> U/K	<p>b. Position of child:</p> <p><input type="radio"/> Driver</p> <p><input type="radio"/> Passenger      If passenger, relationship of driver to child:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Front seat</td> <td><input type="radio"/> Biological parent</td> </tr> <tr> <td><input type="radio"/> Back seat</td> <td><input type="radio"/> Adoptive parent</td> </tr> <tr> <td><input type="radio"/> Truck bed</td> <td><input type="radio"/> Stepparent</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Foster parent</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Mother's partner</td> </tr> <tr> <td><input type="radio"/> On bicycle</td> <td><input type="radio"/> Father's partner</td> </tr> <tr> <td><input type="radio"/> Pedestrian</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Walking</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Boarding/blading</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<input type="radio"/> Front seat	<input type="radio"/> Biological parent	<input type="radio"/> Back seat	<input type="radio"/> Adoptive parent	<input type="radio"/> Truck bed	<input type="radio"/> Stepparent	<input type="radio"/> Other, specify:	<input type="radio"/> Foster parent	<input type="radio"/> U/K	<input type="radio"/> Mother's partner	<input type="radio"/> On bicycle	<input type="radio"/> Father's partner	<input type="radio"/> Pedestrian	<input type="radio"/> Grandparent	<input type="radio"/> Walking	<input type="radio"/> Sibling	<input type="radio"/> Boarding/blading	<input type="radio"/> Other relative	<input type="radio"/> Other, specify:	<input type="radio"/> Friend	<input type="radio"/> U/K	<input type="radio"/> Other, specify:	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>c. Causes of incident, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Back/front over</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Flipover</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Ran stop sign or red light</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Driver distraction</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Driver inexperience</td> <td><input type="checkbox"/> Animal in road</td> </tr> <tr> <td><input type="checkbox"/> Mechanical failure</td> <td><input type="checkbox"/> Cell phone use while driving</td> </tr> <tr> <td><input type="checkbox"/> Poor tires</td> <td><input type="checkbox"/> Racing, not authorized</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Drugs or alcohol use</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/sleeping</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical event, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Back/front over	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Flipover	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Animal in road	<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Cell phone use while driving	<input type="checkbox"/> Poor tires	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Poor weather	<input type="checkbox"/> Other driver error, specify:	<input type="checkbox"/> Poor visibility	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Drugs or alcohol use	<input type="checkbox"/> U/K	<input type="checkbox"/> Fatigue/sleeping		<input type="checkbox"/> Medical event, specify:	
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<p>d. Collision type:</p> <p><input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle</p> <p><input type="radio"/> Child in/on a vehicle, struck by other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck person/object</p> <p><input type="radio"/> Other event, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Driving conditions, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Inadequate lighting</td> </tr> <tr> <td><input type="checkbox"/> Loose gravel</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Muddy</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Ice/snow</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fog</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Wet</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Construction zone</td> <td></td> </tr> </table>	<input type="checkbox"/> Normal	<input type="checkbox"/> Inadequate lighting	<input type="checkbox"/> Loose gravel	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Muddy	<input type="checkbox"/> U/K	<input type="checkbox"/> Ice/snow		<input type="checkbox"/> Fog		<input type="checkbox"/> Wet		<input type="checkbox"/> Construction zone		<p>f. Location of incident, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> City street</td> <td><input type="checkbox"/> Driveway</td> </tr> <tr> <td><input type="checkbox"/> Residential street</td> <td><input type="checkbox"/> Parking area</td> </tr> <tr> <td><input type="checkbox"/> Rural road</td> <td><input type="checkbox"/> Off road</td> </tr> <tr> <td><input type="checkbox"/> Highway</td> <td><input type="checkbox"/> RR xing/tracks</td> </tr> <tr> <td><input type="checkbox"/> Intersection</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> City street	<input type="checkbox"/> Driveway	<input type="checkbox"/> Residential street	<input type="checkbox"/> Parking area	<input type="checkbox"/> Rural road	<input type="checkbox"/> Off road	<input type="checkbox"/> Highway	<input type="checkbox"/> RR xing/tracks	<input type="checkbox"/> Intersection	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Shoulder		<input type="checkbox"/> Sidewalk	<input type="checkbox"/> U/K																																																																
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g. Drivers involved in incident, check all that apply:

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

h. Total number of occupants in vehicles:

In child's vehicle, including child:	In other primary vehicle involved in incident:
<input type="checkbox"/> N/A, child was not in a vehicle	<input type="checkbox"/> N/A, incident was a single vehicle crash
Total number of occupants: _____ <input type="checkbox"/> U/K	Total number of occupants: _____ <input type="checkbox"/> U/K
Number of teens, ages 14-21: _____ <input type="checkbox"/> U/K	Number of teens, ages 14-21: _____ <input type="checkbox"/> U/K
Total number of deaths: _____ <input type="checkbox"/> U/K	Total number of deaths: _____ <input type="checkbox"/> U/K
Total number of teen deaths: _____ <input type="checkbox"/> U/K	Total number of teen deaths: _____ <input type="checkbox"/> U/K

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

	Not Needed	Needed, none present	Present, used correctly	Present, used incorrectly	Present, not used	U/K
Airbag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lap belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child seat*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belt positioning booster seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Helmet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*If child seat, type:  
 Rear facing  
 Front facing  
 U/K

**2. FIRE, BURN, OR ELECTROCUTION**

a. Ignition, heat or electrocution source:				b. Type of incident:		c. For fire, child died from:	
<input type="radio"/> Matches	<input type="radio"/> Heating stove	<input type="radio"/> Lightning	<input type="radio"/> Other explosives	<input type="radio"/> Fire, go to c		<input type="radio"/> Burns	
<input type="radio"/> Cigarette lighter	<input type="radio"/> Space heater	<input type="radio"/> Oxygen tank	<input type="radio"/> Appliance in water	<input type="radio"/> Scald, go to r		<input type="radio"/> Smoke inhalation	
<input type="radio"/> Utility lighter	<input type="radio"/> Furnace	<input type="radio"/> Hot cooking water	<input type="radio"/> Other, specify:	<input type="radio"/> Other burn, go to t		<input type="radio"/> Other, specify:	
<input type="radio"/> Cigarette or cigar	<input type="radio"/> Power line	<input type="radio"/> Hot bath water		<input type="radio"/> Electrocution, go to s			
<input type="radio"/> Candles	<input type="radio"/> Electrical outlet	<input type="radio"/> Other hot liquid, specify:		<input type="radio"/> Other, specify and go to t		<input type="radio"/> U/K	
<input type="radio"/> Cooking stove	<input type="radio"/> Electrical wiring	<input type="radio"/> Fireworks	<input type="radio"/> U/K	<input type="radio"/> U/K, go to t			

d. Material first ignited:	e. Type of building on fire:	f. Building's primary construction material:	g. Fire started by a person?	h. Did anyone attempt to put out fire?
<input type="radio"/> Upholstery	<input type="radio"/> N/A	<input type="radio"/> Wood	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Mattress	<input type="radio"/> Single home	<input type="radio"/> Steel	If yes, person's age _____	i. Did escape or rescue efforts worsen fire?
<input type="radio"/> Christmas tree	<input type="radio"/> Duplex	<input type="radio"/> Brick/stone	Does person have a history of setting fires?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Clothing	<input type="radio"/> Apartment	<input type="radio"/> Aluminum	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	j. Did any factors delay fire department arrival?
<input type="radio"/> Curtain	<input type="radio"/> Trailer/mobile home	<input type="radio"/> Other, specify:		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> U/K		If yes, specify:
<input type="radio"/> U/K	<input type="radio"/> U/K			

k. Were barriers preventing safe exit?	l. Was building a rental property?	m. Were building/rental codes violated?	n. Were proper working fire extinguishers present?
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
If yes, check all that apply:	o. Was sprinkler system present?	p. Were smoke detectors present?	
<input type="checkbox"/> Locked door	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<input type="checkbox"/> Window grate	If yes, was it working?	If yes, what type?	If yes, functioning properly?
<input type="checkbox"/> Locked window	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Removable batteries	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> Blocked stairway		<input type="checkbox"/> Non-removable batteries	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Hardwired	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> U/K		<input type="checkbox"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
			If not functioning properly, reason:
			Missing batteries <input type="checkbox"/> Other <input type="checkbox"/> U/K <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			Other, specify: _____
			If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K



<p>q. Suspected arson?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>r. For scald, was hot water heater set too high?  <input type="radio"/> N/A  <input type="radio"/> Yes, temp. setting: _____  <input type="radio"/> No  <input type="radio"/> U/K</p>	<p>s. For electrocution, what cause:  <input type="radio"/> Electrical storm  <input type="radio"/> Faulty wiring  <input type="radio"/> Wire/product in water  <input type="radio"/> Child playing with outlet  <input type="radio"/> Other, specify:  <input type="radio"/> U/K</p>	<p>t. Other, describe in detail:</p>
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### 3. DROWNING

<p>a. Where was child last seen before drowning? Check all that apply:</p> <p><input type="checkbox"/> In water <input type="checkbox"/> In yard  <input type="checkbox"/> On shore <input type="checkbox"/> In bathroom  <input type="checkbox"/> On dock <input type="checkbox"/> In house  <input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K</p>	<p>b. What was child last seen doing before drowning?</p> <p><input type="radio"/> Playing <input type="radio"/> Tubing  <input type="radio"/> Boating <input type="radio"/> Waterskiing  <input type="radio"/> Swimming <input type="radio"/> Sleeping  <input type="radio"/> Bathing <input type="radio"/> Other, specify:  <input type="radio"/> Fishing  <input type="radio"/> Surfing <input type="radio"/> U/K</p>	<p>c. Was child forcibly submerged?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>d. Drowning location:  <input type="radio"/> Open water, go to e <input type="radio"/> U/K, go to n  <input type="radio"/> Pool, hot tub, spa, go to i  <input type="radio"/> Bathtub, go to w  <input type="radio"/> Bucket, go to x  <input type="radio"/> Well/cistern/septic, go to n  <input type="radio"/> Toilet, go to z  <input type="radio"/> Other, specify and go to n</p>	
<p>e. For open water, place:  <input type="radio"/> Lake <input type="radio"/> Quarry  <input type="radio"/> River <input type="radio"/> Gravel pit  <input type="radio"/> Pond <input type="radio"/> Canal  <input type="radio"/> Creek <input type="radio"/> U/K  <input type="radio"/> Ocean</p>	<p>f. For open water, contributing environmental factors:  <input type="radio"/> Weather <input type="radio"/> Drop off  <input type="radio"/> Temperature <input type="radio"/> Rough waves  <input type="radio"/> Current <input type="radio"/> Other, specify:  <input type="radio"/> Riptide/undertow <input type="radio"/> U/K</p>	<p>g. If boating, type of boat:  <input type="radio"/> Sailboat <input type="radio"/> Commercial  <input type="radio"/> Jet ski <input type="radio"/> Other, specify:  <input type="radio"/> Motorboat  <input type="radio"/> Canoe  <input type="radio"/> Kayak <input type="radio"/> U/K  <input type="radio"/> Raft</p>	<p>h. For boating, was the child piloting boat?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	
<p>i. For pool, type of pool:  <input type="radio"/> Above ground  <input type="radio"/> In-ground <input type="radio"/> Hot tub, spa  <input type="radio"/> Wading <input type="radio"/> U/K</p>	<p>j. For pool, child found:  <input type="radio"/> In the pool/hot tub/spa  <input type="radio"/> On or under the cover  <input type="radio"/> U/K</p>	<p>k. For pool, ownership is:  <input type="radio"/> Private  <input type="radio"/> Public  <input type="radio"/> U/K</p>	<p>l. Length of time owners had pool/hot tub/spa:  <input type="radio"/> N/A <input type="radio"/> &gt;1yr  <input type="radio"/> &lt;6 months <input type="radio"/> U/K  <input type="radio"/> 6m-1 yr</p>	
<p>m. Flotation device used?  <input type="radio"/> N/A  <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Coast Guard approved <input type="checkbox"/> Not Coast Guard approved <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Jacket <input type="checkbox"/> Cushion <input type="checkbox"/> Lifesaving ring</p> <p>If jacket:  Correct size? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  Worn correctly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p><input type="checkbox"/> Swim rings  <input type="checkbox"/> Inner tube  <input type="checkbox"/> Air mattress  <input type="checkbox"/> Other, specify:</p>			<p>n. What barriers/layers of protection existed to prevent access to water?  Check all that apply:  <input type="checkbox"/> None <input type="checkbox"/> Alarm, go to r  <input type="checkbox"/> Fence, go to o <input type="checkbox"/> Cover, go to s  <input type="checkbox"/> Gate, go to p <input type="checkbox"/> U/K  <input type="checkbox"/> Door, go to q</p>	
<p>o. Fence:  Describe type:  Fence height in ft _____  Fence surrounds water on:  <input type="radio"/> Four sides <input type="radio"/> Two or  <input type="radio"/> Three sides less sides  <input type="radio"/> U/K</p>	<p>p. Gate, check all that apply:  <input type="checkbox"/> Has self-closing latch  <input type="checkbox"/> Has lock  <input type="checkbox"/> Is a double gate  <input type="checkbox"/> Opens to water  <input type="checkbox"/> U/K</p>	<p>q. Door, check all that apply:  <input type="checkbox"/> Patio door <input type="checkbox"/> Opens to water  <input type="checkbox"/> Screen door <input type="checkbox"/> Barrier between  <input type="checkbox"/> Steel door door and water  <input type="checkbox"/> Self-closing <input type="checkbox"/> U/K  <input type="checkbox"/> Has lock</p>	<p>r. Alarm, check all that apply:  <input type="checkbox"/> Door  <input type="checkbox"/> Window  <input type="checkbox"/> Pool  <input type="checkbox"/> Laser  <input type="checkbox"/> U/K</p>	<p>s. Type of cover:  <input type="radio"/> Hard  <input type="radio"/> Soft  <input type="radio"/> U/K</p>
<p>t. Local ordinance(s) regulating access to water?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, rules violated?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>u. How were layers of protection breached? Check all that apply:</p> <p><input type="checkbox"/> No layers breached <input type="checkbox"/> Gap in fence <input type="checkbox"/> Door screen torn <input type="checkbox"/> Cover left off  <input type="checkbox"/> Gate left open <input type="checkbox"/> Damaged fence <input type="checkbox"/> Door self-closer failed <input type="checkbox"/> Cover not locked  <input type="checkbox"/> Gate unlocked <input type="checkbox"/> Fence too short <input type="checkbox"/> Window left open <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Gate latch failed <input type="checkbox"/> Door left open <input type="checkbox"/> Window screen torn  <input type="checkbox"/> Gap in gate <input type="checkbox"/> Door unlocked <input type="checkbox"/> Alarm not working  <input type="checkbox"/> Climbed fence <input type="checkbox"/> Door broken <input type="checkbox"/> Alarm not answered <input type="checkbox"/> U/K</p>			
<p>v. Child able to swim?  <input type="radio"/> N/A <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>w. For bathtub, child in a bathing aid?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, specify type:</p>	<p>x. Warning sign or label posted?  <input type="radio"/> N/A <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>y. Lifeguard present?  <input type="radio"/> N/A <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> U/K</p>	
<p>z. Rescue attempt made?  <input type="radio"/> N/A  <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> U/K</p> <p>If yes, who? Check all that apply:  <input type="checkbox"/> Parent <input type="checkbox"/> Bystander  <input type="checkbox"/> Other child <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Lifeguard <input type="checkbox"/> U/K</p>		<p>aa. Did rescuer(s) also drown?  <input type="radio"/> N/A <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, number of rescuers that drowned: _____</p>	<p>bb. Appropriate rescue equipment present?  <input type="radio"/> N/A <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> U/K</p>	



#### 4. ASPHYXIA

<p>a. Type of event:</p> <p><input type="radio"/> Suffocation, go to b</p> <p><input type="radio"/> Strangulation, go to c</p> <p><input type="radio"/> Choking, go to d</p> <p><input type="radio"/> Other, specify and go to e</p> <p><input type="radio"/> U/K, go to e</p>	<p>b. If suffocation/asphyxia, action causing event:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)</td> <td><input type="radio"/> Confined in tight space</td> <td><input type="radio"/> Swaddled in tight blanket, but not sleep-related</td> </tr> <tr> <td><input type="radio"/> Covered in or fell into object, but not sleep-related</td> <td><input type="radio"/> Refrigerator/freezer</td> <td><input type="radio"/> Wedged into tight space, but not sleep-related</td> </tr> <tr> <td><input type="radio"/> Plastic bag</td> <td><input type="radio"/> Toy chest</td> <td><input type="radio"/> Asphyxia by gas, go to G8h</td> </tr> <tr> <td><input type="radio"/> Dirt/sand</td> <td><input type="radio"/> Automobile</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Trunk</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> U/K</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)	<input type="radio"/> Confined in tight space	<input type="radio"/> Swaddled in tight blanket, but not sleep-related	<input type="radio"/> Covered in or fell into object, but not sleep-related	<input type="radio"/> Refrigerator/freezer	<input type="radio"/> Wedged into tight space, but not sleep-related	<input type="radio"/> Plastic bag	<input type="radio"/> Toy chest	<input type="radio"/> Asphyxia by gas, go to G8h	<input type="radio"/> Dirt/sand	<input type="radio"/> Automobile	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> Trunk	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="radio"/> Other, specify:			<input type="radio"/> U/K			<input type="radio"/> Other, specify:			<input type="radio"/> U/K	
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	<input type="radio"/> U/K																											
	<input type="radio"/> Other, specify:																											
	<input type="radio"/> U/K																											

<p>c. If strangulation, object causing event:</p> <p><input type="radio"/> Clothing      <input type="radio"/> Leash</p> <p><input type="radio"/> Blind cord      <input type="radio"/> Electrical cord</p> <p><input type="radio"/> Car seat      <input type="radio"/> Person, go to G5q</p> <p><input type="radio"/> Stroller      <input type="radio"/> Automobile power window</p> <p><input type="radio"/> High chair      or sunroof</p> <p><input type="radio"/> Belt      <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Rope/string      <input type="radio"/> U/K</p>	<p>d. If choking, object causing choking:</p> <p><input type="radio"/> Food, specify:</p> <p><input type="radio"/> Toy, specify:</p> <p><input type="radio"/> Balloon</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Was asphyxia an autoerotic event?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<p>g. History of seizures?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K   If yes, # _____</p> <p>If yes, witnessed? <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>
		<p>f. Was child participating in 'choking game' or 'pass out game'?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<p>h. History of apnea?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K   If yes, # _____</p> <p>If yes, witnessed? <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>
			<p>i. Was Heimlich Maneuver attempted?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>

#### 5. WEAPON, INCLUDING PERSON'S BODY PART

<p>a. Type of weapon:</p> <p><input type="radio"/> Firearm, go to b</p> <p><input type="radio"/> Sharp instrument, go to j</p> <p><input type="radio"/> Blunt instrument, go to k</p> <p><input type="radio"/> Person's body part, go to l</p> <p><input type="radio"/> Explosive, go to m</p> <p><input type="radio"/> Rope, go to m</p> <p><input type="radio"/> Pipe, go to m</p> <p><input type="radio"/> Biological, go to m</p> <p><input type="radio"/> Other, specify and go to m</p> <p><input type="radio"/> U/K, go to m</p>	<p>b. For firearms, type:</p> <p><input type="radio"/> Handgun</p> <p><input type="radio"/> Shotgun</p> <p><input type="radio"/> BB gun</p> <p><input type="radio"/> Hunting rifle</p> <p><input type="radio"/> Assault rifle</p> <p><input type="radio"/> Air rifle</p> <p><input type="radio"/> Sawed off shotgun</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>c. Firearm licensed?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>	<p>d. Firearm safety features, check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Trigger lock</td> <td><input type="checkbox"/> Magazine disconnect</td> </tr> <tr> <td><input type="checkbox"/> Personalization device</td> <td><input type="checkbox"/> Minimum trigger pull</td> </tr> <tr> <td><input type="checkbox"/> External safety/drop safety</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Loaded chamber indicator</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Trigger lock	<input type="checkbox"/> Magazine disconnect	<input type="checkbox"/> Personalization device	<input type="checkbox"/> Minimum trigger pull	<input type="checkbox"/> External safety/drop safety	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Loaded chamber indicator	<input type="checkbox"/> U/K
<input type="checkbox"/> Trigger lock	<input type="checkbox"/> Magazine disconnect										
<input type="checkbox"/> Personalization device	<input type="checkbox"/> Minimum trigger pull										
<input type="checkbox"/> External safety/drop safety	<input type="checkbox"/> Other, specify:										
<input type="checkbox"/> Loaded chamber indicator	<input type="checkbox"/> U/K										
		<p>e. Where was firearm stored?</p> <p><input type="radio"/> Not stored      <input type="radio"/> Under mattress/pillow</p> <p><input type="radio"/> Locked cabinet      <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Unlocked cabinet</p> <p><input type="radio"/> Glove compartment      <input type="radio"/> U/K</p>	<p>f. Firearm stored with ammunition?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>								
			<p>g. Firearm stored loaded?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>								

<p>h. Owner of fatal firearm:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> U/K, weapon stolen</td> <td><input type="radio"/> Grandparent</td> <td><input type="radio"/> Co-worker</td> </tr> <tr> <td><input type="radio"/> U/K, weapon found</td> <td><input type="radio"/> Sibling</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Self</td> <td><input type="radio"/> Spouse</td> <td><input type="radio"/> Neighbor</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Other relative</td> <td><input type="radio"/> Rival gang member</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Friend</td> <td><input type="radio"/> Stranger</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Acquaintance</td> <td><input type="radio"/> Law enforcement</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Child's boyfriend or girlfriend</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Classmate</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td></td> <td></td> </tr> </table>	<input type="radio"/> U/K, weapon stolen	<input type="radio"/> Grandparent	<input type="radio"/> Co-worker	<input type="radio"/> U/K, weapon found	<input type="radio"/> Sibling	<input type="radio"/> Institutional staff	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Neighbor	<input type="radio"/> Biological parent	<input type="radio"/> Other relative	<input type="radio"/> Rival gang member	<input type="radio"/> Adoptive parent	<input type="radio"/> Friend	<input type="radio"/> Stranger	<input type="radio"/> Stepparent	<input type="radio"/> Acquaintance	<input type="radio"/> Law enforcement	<input type="radio"/> Foster parent	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/> Other, specify:	<input type="radio"/> Mother's partner	<input type="radio"/> Classmate	<input type="radio"/> U/K	<input type="radio"/> Father's partner			<p>i. Sex of fatal firearm owner:</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> <p><input type="radio"/> U/K</p>	<p>j. Type of sharp object:</p> <p><input type="radio"/> Kitchen knife</p> <p><input type="radio"/> Switchblade</p> <p><input type="radio"/> Pocketknife</p> <p><input type="radio"/> Razor</p> <p><input type="radio"/> Hunting knife</p> <p><input type="radio"/> Scissors</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>k. Type of blunt object:</p> <p><input type="radio"/> Bat</p> <p><input type="radio"/> Club</p> <p><input type="radio"/> Stick</p> <p><input type="radio"/> Hammer</p> <p><input type="radio"/> Rock</p> <p><input type="radio"/> Household item</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>
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<input type="radio"/> Biological parent	<input type="radio"/> Other relative	<input type="radio"/> Rival gang member																												
<input type="radio"/> Adoptive parent	<input type="radio"/> Friend	<input type="radio"/> Stranger																												
<input type="radio"/> Stepparent	<input type="radio"/> Acquaintance	<input type="radio"/> Law enforcement																												
<input type="radio"/> Foster parent	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/> Other, specify:																												
<input type="radio"/> Mother's partner	<input type="radio"/> Classmate	<input type="radio"/> U/K																												
<input type="radio"/> Father's partner																														

<p>l. What did person's body part do? Check all that apply:</p> <p><input type="checkbox"/> Beat, kick or punch</p> <p><input type="checkbox"/> Drop</p> <p><input type="checkbox"/> Push</p> <p><input type="checkbox"/> Bite</p> <p><input type="checkbox"/> Shake</p> <p><input type="checkbox"/> Strangle</p> <p><input type="checkbox"/> Throw</p> <p><input type="checkbox"/> Drown</p> <p><input type="checkbox"/> Burn</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>m. Did person using weapon have history of weapon-related offenses?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</p> <p><input type="radio"/> Yes, describe circumstances:</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width: 100%;"> <tr> <th colspan="2">Fatal and/or Other weapon</th> <th colspan="2">Fatal and/or Other weapon</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>	Fatal and/or Other weapon		Fatal and/or Other weapon		<input type="checkbox"/>	<input type="checkbox"/> Self	<input type="checkbox"/>	<input type="checkbox"/> Friend	<input type="checkbox"/>	<input type="checkbox"/> Biological parent	<input type="checkbox"/>	<input type="checkbox"/> Acquaintance	<input type="checkbox"/>	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/>	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/>	<input type="checkbox"/> Stepparent	<input type="checkbox"/>	<input type="checkbox"/> Classmate	<input type="checkbox"/>	<input type="checkbox"/> Foster parent	<input type="checkbox"/>	<input type="checkbox"/> Co-worker	<input type="checkbox"/>	<input type="checkbox"/> Mother's partner	<input type="checkbox"/>	<input type="checkbox"/> Institutional staff	<input type="checkbox"/>	<input type="checkbox"/> Father's partner	<input type="checkbox"/>	<input type="checkbox"/> Neighbor	<input type="checkbox"/>	<input type="checkbox"/> Grandparent	<input type="checkbox"/>	<input type="checkbox"/> Rival gang member	<input type="checkbox"/>	<input type="checkbox"/> Sibling	<input type="checkbox"/>	<input type="checkbox"/> Stranger	<input type="checkbox"/>	<input type="checkbox"/> Spouse	<input type="checkbox"/>	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/>	<input type="checkbox"/> Other relative	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:			<input type="checkbox"/>	<input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> <p><input type="radio"/> U/K</p> <p>Other weapon:</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> <p><input type="radio"/> U/K</p>
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<input type="checkbox"/>	<input type="checkbox"/> Mother's partner	<input type="checkbox"/>	<input type="checkbox"/> Institutional staff																																																					
<input type="checkbox"/>	<input type="checkbox"/> Father's partner	<input type="checkbox"/>	<input type="checkbox"/> Neighbor																																																					
<input type="checkbox"/>	<input type="checkbox"/> Grandparent	<input type="checkbox"/>	<input type="checkbox"/> Rival gang member																																																					
<input type="checkbox"/>	<input type="checkbox"/> Sibling	<input type="checkbox"/>	<input type="checkbox"/> Stranger																																																					
<input type="checkbox"/>	<input type="checkbox"/> Spouse	<input type="checkbox"/>	<input type="checkbox"/> Law enforcement officer																																																					
<input type="checkbox"/>	<input type="checkbox"/> Other relative	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:																																																					
		<input type="checkbox"/>	<input type="checkbox"/> U/K																																																					

q. Use of weapon at time, check all that apply:

<input type="checkbox"/> Self injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)
<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity	
<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon	
<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> U/K

**6. ANIMAL BITE OR ATTACK**

<p>a. Type of animal:</p> <input type="radio"/> Domesticated dog <input type="radio"/> Insect <input type="radio"/> Domesticated cat <input type="radio"/> Other, specify: <input type="radio"/> Snake <input type="radio"/> Wild mammal, specify: <input type="radio"/> U/K	<p>b. Animal access to child, check all that apply:</p> <input type="checkbox"/> Animal on leash <input type="checkbox"/> Animal escaped from cage or leash <input type="checkbox"/> Animal caged or inside fence <input type="checkbox"/> Animal not caged or leashed <input type="radio"/> Child reached in <input type="checkbox"/> U/K <input type="radio"/> Child entered animal area <input type="radio"/> U/K	<p>c. Did child provoke animal?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how?
		<p>d. Animal has history of biting or attacking?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

**7. FALL OR CRUSH**

<p>a. Type:</p> <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	<p>b. Height of fall:</p> _____ feet _____ inches <input type="checkbox"/> U/K	<p>c. Child fell from:</p> <input type="radio"/> Open window <input type="radio"/> Natural elevation <input type="radio"/> Stairs/steps <input type="radio"/> Moving object, specify: <input type="radio"/> Animal, specify: <input type="radio"/> Screen <input type="radio"/> Man-made elevation <input type="radio"/> Furniture <input type="radio"/> Bridge <input type="radio"/> Other, specify: <input type="radio"/> No screen <input type="radio"/> Playground equipment <input type="radio"/> Bed <input type="radio"/> Overpass <input type="radio"/> U/K if screen <input type="radio"/> Tree <input type="radio"/> Roof <input type="radio"/> Balcony <input type="radio"/> U/K		
<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Grass <input type="radio"/> Gravel <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> Linoleum/vinyl <input type="radio"/> Marble/tile <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Barrier in place:</p> Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Screen <input type="checkbox"/> Other window guard <input type="checkbox"/> Fence <input type="checkbox"/> Railing <input type="checkbox"/> Stairway <input type="checkbox"/> Gate <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Child in a baby walker?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>g. Was child pushed, dropped or thrown?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, go to G5q	<p>h. For crush, did child:</p> <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Dirt/sand <input type="radio"/> Television <input type="radio"/> Person, go to G5q <input type="radio"/> Furniture <input type="radio"/> Commercial equipment <input type="radio"/> Walls <input type="radio"/> Farm equipment <input type="radio"/> Playground equipment <input type="radio"/> Other, specify: <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> U/K <input type="radio"/> Boulders/rocks

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

<p>a. Type of substance involved, check all that apply:</p> <table border="0"> <tr> <td> <u>Prescription drug</u>  <input type="checkbox"/> Antidepressant  <input type="checkbox"/> Blood pressure medication  <input type="checkbox"/> Pain killer (opiate)  <input type="checkbox"/> Pain killer (non-opiate)  <input type="checkbox"/> Methadone  <input type="checkbox"/> Cardiac medication  <input type="checkbox"/> Other, specify:         </td> <td> <u>Over-the-counter drug</u>  <input type="checkbox"/> Diet pills  <input type="checkbox"/> Stimulants  <input type="checkbox"/> Cough medicine  <input type="checkbox"/> Pain medication  <input type="checkbox"/> Children's vitamins  <input type="checkbox"/> Iron supplement  <input type="checkbox"/> Other vitamins  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Cosmetics/personal care products         </td> <td> <u>Cleaning substances</u>  <input type="checkbox"/> Bleach  <input type="checkbox"/> Drain cleaner  <input type="checkbox"/> Alkaline-based cleaner  <input type="checkbox"/> Solvent  <input type="checkbox"/> Other, specify:         </td> <td> <u>Other substances</u>  <input type="checkbox"/> Plants  <input type="checkbox"/> Alcohol  <input type="checkbox"/> Street drugs  <input type="checkbox"/> Pesticide  <input type="checkbox"/> Antifreeze  <input type="checkbox"/> Other chemical  <input type="checkbox"/> Herbal remedy  <input type="checkbox"/> Carbon monoxide, go to f  <input type="checkbox"/> Other fume/gas/vapor  <input type="checkbox"/> Other, specify:         </td> <td><input type="checkbox"/> U/K</td> </tr> </table>					<u>Prescription drug</u> <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify:	<u>Over-the-counter drug</u> <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products	<u>Cleaning substances</u> <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify:	<u>Other substances</u> <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to f <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K
<u>Prescription drug</u> <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify:	<u>Over-the-counter drug</u> <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products	<u>Cleaning substances</u> <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify:	<u>Other substances</u> <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to f <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K					
<p>b. Where was the substance stored?</p> <input type="radio"/> Open area <input type="radio"/> Open cabinet <input type="radio"/> Closed cabinet, unlocked <input type="radio"/> Closed cabinet, locked <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Was the product in its original container?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Did container have a child safety cap?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>e. If prescription, was it child's?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>f. Was the incident the result of?</p> <input type="radio"/> Accidental overdose <input type="radio"/> Medical treatment mishap <input type="radio"/> Adverse effect, but not overdose <input type="radio"/> Deliberate poisoning <input type="radio"/> Acute intoxication <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>g. Was Poison Control called?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, who called: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Other caregiver <input type="radio"/> First responder <input type="radio"/> Medical person <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>h. For CO poisoning, was a CO detector present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many? _____ Functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

**9. EXPOSURE**

a. Circumstances, check all that apply: <input type="checkbox"/> Abandonment <input type="checkbox"/> Left in car <input type="checkbox"/> Left in room <input type="checkbox"/> Submerged in water <input type="checkbox"/> Injured outdoors	b. Condition of exposure: <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Illegal border crossing <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K _____ Ambient temp, degrees F	c. Number of hours exposed: _____ <input type="checkbox"/> U/K	d. Was child wearing appropriate clothing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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**10. MEDICAL CONDITION**

a. How long did the child have the medical condition? <input type="radio"/> In utero <input type="radio"/> Since birth <input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years <input type="radio"/> U/K	b. Was death expected as a result of the medical condition? <input type="radio"/> N/A not previously diagnosed <input type="radio"/> Yes <input type="checkbox"/> But at a later date <input type="radio"/> No <input type="radio"/> U/K	c. Was child receiving health care for the medical condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, within 48 hours of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Were the prescribed care plans appropriate for the medical condition? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K
e. Was child/family compliant with the prescribed care plans? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, what wasn't compliant? Check all that apply.		f. Was child up to date with American Academy of Pediatrics immunization schedule? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K	g. Was the medical condition associated with an outbreak? <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> U/K

h. Was environmental tobacco exposure a contributing factor in death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	i. Were there access or compliance issues related to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Language barriers <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Referrals not made <input type="checkbox"/> Caregiver unskilled in providing care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Caregiver unwilling to provide care <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Caregiver's partner would not allow care <input type="checkbox"/> No phone <input type="checkbox"/> Lack of child care <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cultural differences <input type="checkbox"/> Lack of family or social support <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Services not available <input type="checkbox"/> U/K
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**11. OTHER KNOWN INJURY CAUSE**

Specify cause, describe in detail:

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

**1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG**

a. Was this death a homicide, suicide, overdose, injury with the external cause as the only and obvious cause of death or a death which was expected within 6 months due to terminal illness?  Yes  No  U/K If yes, go to Section H2

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

Symptom	Present w/in 72 hours of death			Symptom	Present w/in 72 hours of death		
	Yes	No	U/K		Yes	No	U/K
<b>Cardiac</b>				<b>Other Acute Symptoms</b>			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness/lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heat exhaustion/heat stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle aches/cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Neurologic</b>				Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>		
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Head injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Psychiatric symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Paralysis (acute)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>Respiratory</b>							
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

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

Symptom	Present more than 72 hours of death		
	Yes	No	U/K
<b>Cardiac</b>			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness/lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Neurologic</b>			
Concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Respiratory</b>			
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Other</b>			
Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>		

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

Yes  No  U/K If yes, describe:

e. Had the child ever been diagnosed by a medical professional for the following?  U/K for all

<u>Condition</u>				<u>Diagnosed</u>			<u>Condition</u>				<u>Diagnosed</u>		
				<u>Yes</u>	<u>No</u>	<u>U/K</u>					<u>Yes</u>	<u>No</u>	<u>U/K</u>
<b><u>Blood disease</u></b>							<b><u>Neurologic (cont)</u></b>						
Sickle cell disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy/seizure disorder				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sickle cell trait				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Febrile seizure				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thrombophilia (clotting disorder)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mesial temporal sclerosis				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b><u>Cardiac</u></b>							Neurodegenerative disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal electrocardiogram (EKG or ECG)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke/mini stroke/				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aneurysm or aortic dilatation				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TIA-Transient Ischemic Attack						
Arrhythmia/arrhythmia syndrome				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Central nervous system infection (meningitis or encephalitis)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiomyopathy				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b><u>Respiratory</u></b>						
Commotio cordis				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Apnea				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congenital heart disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery abnormality				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary embolism				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery disease (atherosclerosis)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary hemorrhage				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocarditis				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory arrest				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart failure				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b><u>Other</u></b>						
Heart murmur				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Connective tissue disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Endocrine disorder, other: thyroid, adrenal, pituitary				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Myocarditis (heart infection)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hearing problems or deafness				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulmonary hypertension				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kidney disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden cardiac arrest				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental illness/psychiatric disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b><u>Neurologic</u></b>							Metabolic disease				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anoxic brain Injury				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle disorder or muscular dystrophy				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traumatic brain injury/ head injury/concussion				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oncologic disease treated by chemotherapy or radiation				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain tumor				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prematurity				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain aneurysm				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital disorder/ genetic syndrome				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain hemorrhage				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:				<input type="radio"/>		
Developmental brain disorder				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply:  None

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cardiac ablation  | <input type="checkbox"/> Heart surgery                          | <input type="checkbox"/> Heart transplant |
| <input type="checkbox"/> Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD)) | <input type="checkbox"/> Interventional cardiac catheterization | <input type="checkbox"/> Other, specify:  |
|  |   | <input type="checkbox"/> U/K              |

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms?  U/K for all

<u>Y</u>	<u>N</u>	<u>U/K</u>	<u>Deaths</u>	<u>Y</u>	<u>N</u>	<u>U/K</u>	<u>Symptoms</u>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sudden unexpected death before age 50	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Febrile seizures
			<b><u>Heart Disease</u></b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unexplained fainting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart condition/heart attack or stroke before age 50				<b><u>Other Diagnoses</u></b>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Aortic aneurysm or aortic rupture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital deafness
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arrhythmia (fast or irregular heart rhythm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Connective tissue disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cardiomyopathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mitochondrial disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle disorder or muscular dystrophy
			<b><u>Neurologic Disease</u></b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thrombophilia (clotting disorder)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy or convulsions/seizure	<input type="radio"/>			Other diseases that are genetic or run in families, specify:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other neurologic disease				

If sudden unexpected death before age 50, describe (for example, SIDS, drowning, relative who died in single and/or unexplained motor vehicle accident (driver of car)):

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

Yes  No  U/K

If yes, describe what test and/or for what disease and results:

Was a gene mutation found?

Yes  No  U/K

**h. In the 72 hours prior to death was the child taking any prescribed medication(s)?**  
 Yes  No  U/K  
 If yes, describe:

**i. Within 2 weeks prior to death had the child:**

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Missed doses of prescribed medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changed prescribed medications, describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**j. Was the child compliant with their prescribed medications?**  
 N/A  Yes  No  U/K  
 If not compliant, describe why and how often:

**k. Was the child taking any of the following substance(s) within 24 hours of death?**  
**Check all that apply:**

<input type="checkbox"/> Over the counter medicine	<input type="checkbox"/> Supplements
<input type="checkbox"/> Recent/short term prescriptions	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Energy drinks	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Illegal drugs
<input type="checkbox"/> Performance enhancers	<input type="checkbox"/> Legalized marijuana
<input type="checkbox"/> Diet assisting medications	<input type="checkbox"/> Other, specify:
	<input type="checkbox"/> U/K

If yes to any items above, describe:

**l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident?**  U/K for all at time of incident  
 U/K for all within 24 hours of incident

Stimuli	At incident			Within 24 hrs of incident		
	Yes	No	U/K	Yes	No	U/K
Physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep deprivation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visual stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Video game stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Auditory stimuli/startle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>			<input type="radio"/>		

**If yes to physical activity, describe type of activity:**  
 At incident \_\_\_\_\_ Within 24 hours of incident \_\_\_\_\_

**Other specify:**  
 At incident \_\_\_\_\_ Within 24 hours of incident \_\_\_\_\_

**m. Was the child an athlete?**  N/A  Yes  No  U/K  
 If yes, type of sport:  Competitive  Recreational  Unknown  
 If competitive, did the child participate in the 6 months prior to death?  Yes  No  U/K

**n. Did the child ever have any of the following uncharacteristic symptoms during or within 24 hours after physical activity? Check all that apply:**

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Headache
<input type="checkbox"/> Confusion	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Convulsions/seizure	<input type="checkbox"/> Shortness of breath/difficulty breathing
<input type="checkbox"/> Dizziness/lightheadedness	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Fainting	<input type="checkbox"/> U/K

If yes to any item, describe type of physical activity and extent of symptoms:

**o. If child age 12 or older, did the child receive a pre-participation exam for a sport?**  
 N/A  Yes  No  U/K  
 If yes:  
 Was it done within a year prior to death?  Yes  No  U/K  
 Did the exam lead to restrictions for sports or otherwise?  Yes  No  U/K  
 If yes, specify restrictions:

**Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)**

**p. How old was the child when diagnosed with epilepsy/seizure disorder?**  
 Age 0 (infant) through 20 years: \_\_\_\_\_  
 U/K

**q. What were the underlying cause(s) of the child's seizures? Check all that apply:**

<input type="checkbox"/> Brain injury/trauma, specify:	<input type="checkbox"/> Genetic/chromosomal
<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Mesial temporal sclerosis
<input type="checkbox"/> Cerebrovascular	<input type="checkbox"/> Idiopathic or cryptogenic
<input type="checkbox"/> Central nervous system infection	<input type="checkbox"/> Other acute illness or injury other than epilepsy
<input type="checkbox"/> Degenerative process	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Developmental brain disorder	<input type="checkbox"/> U/K
<input type="checkbox"/> Inborn error of metabolism	

**r. What type(s) of seizures did the child have? Check all that apply:**

<input type="checkbox"/> Non-convulsive
<input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure)
<input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)
<input type="checkbox"/> U/K

**s. Describe the child's epilepsy/seizures. Check all that apply:**

<input type="checkbox"/> Last less than 30 minutes
<input type="checkbox"/> Last more than 30 minutes (status epilepticus)
<input type="checkbox"/> Occur in the presence of fever (febrile seizure)
<input type="checkbox"/> Occur in the absence of fever
<input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

**t. How many seizures did the child have in the year preceding death?**  
 0/never  2  More than 3  
 1  3  U/K

**u. Did treatment for seizures include anti-epileptic drugs?**  
 Yes  No  U/K  
 If yes, how many different types of anti-epilepsy drugs (AED) did the child take?  
 1  4  More than 6  
 2  5  U/K  
 3  6

**v. Was night surveillance used?**  
 Yes  No  U/K

**2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?**  Yes, go to H2a  No, go to H2s  U/K, go to H2s

**a. Incident sleep place:**

<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Chair
If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Floor
<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Car seat
<input type="radio"/> Portable, e.g. pack-n-play	<input type="radio"/> Playpen/other play structure	<input type="radio"/> Stroller
<input type="radio"/> Unknown crib type	but not portable crib	<input type="radio"/> Other, specify:
<input type="radio"/> Bassinette	<input type="radio"/> Couch	<input type="radio"/> U/K

**If adult bed, what type?**

<input type="radio"/> Twin
<input type="radio"/> Full
<input type="radio"/> Queen
<input type="radio"/> King
<input type="radio"/> Other, specify:
<input type="radio"/> U/K

**If futon,**

<input type="radio"/> Bed position
<input type="radio"/> Couch position
<input type="radio"/> U/K

<b>b. Child put to sleep:</b> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<b>c. Child found:</b> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<b>e. Usual sleep position:</b> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<b>f. Was there a crib, bassinette or port-a-crib in home for child?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																																																																																																																																							
<b>d. Usual sleep place:</b> <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K		<b>If adult bed, what type?</b> <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K If futon, <input type="radio"/> Bed position <input type="radio"/> U/K <input type="radio"/> Couch position	<b>g. Child in a new or different environment than usual?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:  <b>h. Child last placed to sleep with a pacifier?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <b>i. Child wrapped or swaddled in blanket?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:																																																																																																																																																																																																																																							
<b>j. Child overheated?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, outside temp ____ degrees F Check all that apply: <input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing		<b>k. Child exposed to second hand smoke?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally																																																																																																																																																																																																																																								
<b>l. Child's face when found:</b> <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	<b>m. Child's neck when found:</b> <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> U/K	<b>n. Child's airway:</b> <input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K	<b>If fully or partially obstructed, what was obstructed?</b> <input type="checkbox"/> Nose <input type="checkbox"/> U/K <input type="checkbox"/> Mouth <input type="checkbox"/> Chest compressed																																																																																																																																																																																																																																							
<b>o. Objects in child's sleep environment in relation to airway obstruction:</b> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="3">Objects:</th> <th colspan="5">If present, describe position of object:</th> <th colspan="3">If present, did object obstruct airway?</th> </tr> <tr> <th colspan="2">Present?</th> <th>On top</th> <th>Under</th> <th>Next</th> <th>Tangled</th> <th rowspan="2">Yes</th> <th rowspan="2">No</th> <th rowspan="2">U/K</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>U/K</th> <th>of child</th> <th>child</th> <th>to child</th> <th>around child</th> <th>U/K</th> </tr> </thead> <tbody> <tr> <td>Adult(s)</td> <td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td><input type="radio"/></td><td><input type="radio"/></td><td><input 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Caregiver/supervisor fell asleep while feeding child?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> U/K <input type="radio"/> Breast	
Objects:	If present, describe position of object:					If present, did object obstruct airway?																																																																																																																																																																																																																																				
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Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Boppy or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
Other(s), specify:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																																																																																																																																																																															
<b>q. Child sleeping in the same room as caregiver/supervisor at time of death?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			<b>r. Child sleeping on same surface with person(s) or animal(s)?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> With adult(s): #_____ #U/K Adult obese: <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="checkbox"/> With other children: #_____ #U/K Children's ages: _____ <input type="checkbox"/> With animal(s): #_____ #U/K Type(s) of animal: _____ <input type="checkbox"/> U/K																																																																																																																																																																																																																																							
<b>s. Is there a scene re-creation photo available for upload?</b> <input type="radio"/> Yes <input type="radio"/> No If yes, upload here. Only one photo allowed. Select photo that most describes child placement and relevant objects. Size must be less than 6 mb and in .jpg or .gif format.			<b>3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT?</b> <input type="radio"/> Yes <input type="radio"/> No, go to H4 <input type="radio"/> U/K, go to H4																																																																																																																																																																																																																																							
<b>a. Describe product and circumstances:</b>	<b>b. Was product used properly?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<b>c. Is a recall in place?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<b>d. Did product have safety label?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<b>e. Was Consumer Product Safety Commission (CPSC) notified?</b> <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No, go to www.saferproducts.gov to report																																																																																																																																																																																																																																						

**4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME?**  Yes  No  U/K

**a. Type of crime, check all that apply:**

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

**I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE**

**TYPE OF ACT**

<p><b>1. Did any act(s) of omission or commission cause and/or contribute to the death?</b></p> <p><input type="radio"/> Yes  <input type="radio"/> No, go to Section J  <input type="radio"/> Probable  <input type="radio"/> U/K, go to Section J</p> <p>If yes/probable, were the act(s) either or both?          Check all that apply:</p> <p><input type="checkbox"/> The direct cause of death  <input type="checkbox"/> The contributing cause of death</p>	<p><b>2. What act(s) caused or contributed to the death?</b>          Check only one per column and describe in narrative.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Poor/absent supervision, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child abuse, go to 3</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child neglect, go to 8</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other negligence, go to 9</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Assault, not child abuse, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Religious/cultural practices, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Suicide, go to 27</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Medical misadventure, specify and go to 11</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other, specify and go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K, go to 10</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 10	<input type="radio"/>	<input type="radio"/> Child abuse, go to 3	<input type="radio"/>	<input type="radio"/> Child neglect, go to 8	<input type="radio"/>	<input type="radio"/> Other negligence, go to 9	<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 10	<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 10	<input type="radio"/>	<input type="radio"/> Suicide, go to 27	<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 11	<input type="radio"/>	<input type="radio"/> Other, specify and go to 10	<input type="radio"/>	<input type="radio"/> U/K, go to 10
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<input type="radio"/>	<input type="radio"/> Other, specify and go to 10																						
<input type="radio"/>	<input type="radio"/> U/K, go to 10																						

<p><b>3. Child abuse, type. Check all that apply and describe in narrative.</b></p> <p><input type="checkbox"/> Physical, go to 4  <input type="checkbox"/> Emotional, specify and go to 10  <input type="checkbox"/> Sexual, specify and go to 10  <input type="checkbox"/> U/K, go to 10</p>	<p><b>4. Type of physical abuse, check all that apply:</b></p> <p><input type="checkbox"/> Abusive head trauma, go to 5  <input type="checkbox"/> Chronic Battered Child Syndrome, go to 7  <input type="checkbox"/> Beating/kicking, go to 7  <input type="checkbox"/> Scalding or burning, go to 7  <input type="checkbox"/> Munchausen Syndrome by Proxy, go to 7  <input type="checkbox"/> Other, specify and go to 7  <input type="checkbox"/> U/K, go to 7</p>	<p><b>5. For abusive head trauma, were there retinal hemorrhages?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p><b>6. For abusive head trauma, was the child shaken?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was there impact?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p><b>7. Events(s) triggering physical abuse, check all that apply:</b></p> <p><input type="checkbox"/> None  <input type="checkbox"/> Crying  <input type="checkbox"/> Toilet training  <input type="checkbox"/> Disobedience  <input type="checkbox"/> Feeding problems  <input type="checkbox"/> Domestic argument  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K</p>
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<p><b>8. Child neglect, check all that apply:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Failure to protect from hazards, specify:</td> <td><input type="checkbox"/> Failure to seek/follow treatment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Failure to provide necessities</td> <td><input type="checkbox"/> Emotional neglect, specify:</td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> Abandonment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Shelter</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Failure to protect from hazards, specify:	<input type="checkbox"/> Failure to seek/follow treatment, specify:	<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Emotional neglect, specify:	<input type="checkbox"/> Food	<input type="checkbox"/> Abandonment, specify:	<input type="checkbox"/> Shelter	<input type="checkbox"/> U/K	<input type="checkbox"/> Other, specify:		<p><b>9. Other negligence:</b></p> <p><input type="radio"/> Vehicular  <input type="radio"/> Other, specify:  <input type="radio"/> U/K</p>	<p><b>10. Was act(s) of omission/commission:</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Chronic with child</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Pattern in family or with perpetrator</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Isolated incident</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Chronic with child	<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/> Isolated incident	<input type="radio"/>	<input type="radio"/> U/K
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**PERSON(S) RESPONSIBLE**

<p><b>11. Is person the caregiver or supervisor in previous section?</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, caregiver one, go to 24</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, caregiver two, go to 24</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, supervisor, go to 25</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 24	<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 24	<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 25	<input type="radio"/>	<input type="radio"/> No	<p><b>12. Primary person responsible for action(s) that caused and/or contributed to death:</b>          Select no more than one person for caused and one person for contributed.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Self, go to 24</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Grandparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Medical provider</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Biological parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Sibling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Institutional staff</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Adoptive parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other relative</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Babysitter</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Stepparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Friend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Licensed child care worker</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Foster parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Acquaintance</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other, specify:</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Mother's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child's boyfriend or girlfriend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Father's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Stranger</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Self, go to 24	<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Medical provider	<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Institutional staff	<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative	<input type="radio"/>	<input type="radio"/> Babysitter	<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Licensed child care worker	<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger	<input type="radio"/>	<input type="radio"/>
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<p><b>13. Person's age in years:</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____ # Years</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	_____	_____ # Years	<input type="checkbox"/>	<input type="checkbox"/> U/K	<p><b>14. Person's sex:</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Male</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Female</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Male	<input type="radio"/>	<input type="radio"/> Female	<input type="radio"/>	<input type="radio"/> U/K	<p><b>15. Does person speak English?</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	<p><b>16. Person on active military duty?</b></p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table> <p>If yes, specify branch:</p>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K
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<input type="radio"/>	<input type="radio"/> Female																																
<input type="radio"/>	<input type="radio"/> U/K																																
<u>Caused</u>	<u>Contributed</u>																																
<input type="radio"/>	<input type="radio"/> Yes																																
<input type="radio"/>	<input type="radio"/> No																																
<input type="radio"/>	<input type="radio"/> U/K																																
<u>Caused</u>	<u>Contributed</u>																																
<input type="radio"/>	<input type="radio"/> Yes																																
<input type="radio"/>	<input type="radio"/> No																																
<input type="radio"/>	<input type="radio"/> U/K																																



<p><b>17. Person have history of substance abuse?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p><b>18. Person have history of child maltreatment as victim?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted</p>	<p><b>19. Person have history of child maltreatment as a perpetrator?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed</p>	<p><b>20. Person have disability or chronic illness?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental illness, was person receiving MH services?</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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<p><b>21. Person have prior child deaths?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p><b>22. Person have history of intimate partner violence?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p><b>23. Person have delinquent/criminal history?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
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<p><b>24. At time of incident was person impaired?</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p>	<p><b>25. Does person have, check all that apply:</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions</p>	<p><b>26. Legal outcomes in this death, check all that apply:</b></p> <p><u>Caused</u>   <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
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**FOR SUICIDE**

**27. For suicide, select yes, no or u/k for each question. Describe answers in narrative.**

Yes	No	U/K	Yes	No	U/K
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**28. For suicide, was there a history of acute or cumulative personal crises that may have contributed to the child's despondency? Check all that apply:**

<input type="checkbox"/> None known	<input type="checkbox"/> Suicide by friend or relative	<input type="checkbox"/> Physical abuse/assault	<input type="checkbox"/> Gambling problems
<input type="checkbox"/> Family discord	<input type="checkbox"/> Other death of friend or relative	<input type="checkbox"/> Rape/sexual abuse	<input type="checkbox"/> Involvement in cult activities
<input type="checkbox"/> Parents' divorce/separation	<input type="checkbox"/> Bullying as victim	<input type="checkbox"/> Problems with the law	<input type="checkbox"/> Involvement in computer or video games
<input type="checkbox"/> Argument with parents/caregivers	<input type="checkbox"/> Bullying as perpetrator	<input type="checkbox"/> Drugs/alcohol	<input type="checkbox"/> Involvement with the Internet, specify:
<input type="checkbox"/> Argument with boyfriend/girlfriend	<input type="checkbox"/> School failure	<input type="checkbox"/> Sexual orientation	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Breakup with boyfriend/girlfriend	<input type="checkbox"/> Move/new school	<input type="checkbox"/> Religious/cultural issues	<input type="checkbox"/> U/K
<input type="checkbox"/> Argument with other friends	<input type="checkbox"/> Other serious school problems	<input type="checkbox"/> Job problems	
<input type="checkbox"/> Rumor mongering	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Money problems	

**J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH**

1. Services:	<u>Provided</u>	<u>Offered but</u>	<u>Offered but</u>	<u>Should be</u>	<u>Needed but</u>		<u>CDR review</u>
Select one option per row:	<u>after death</u>	<u>refused</u>	<u>U/K if used</u>	<u>offered</u>	<u>not available</u>	<u>U/K</u>	<u>led to referral</u>
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Debriefing for professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Genetic counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

**K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW**

Mark this case to edit/add prevention actions at a later date

1. Could the death have been prevented?  Yes, probably  No, probably not  Team could not determine
2. What specific recommendations and/or initiatives resulted from the review? Check all that apply:  No recommendations made, go to Section L

	Current Action Stage			Type of Action		Level of Action			
	<u>Recommendation</u>	<u>Planning</u>	<u>Implementation</u>	<u>Short term</u>	<u>Long term</u>	<u>Local</u>	<u>State</u>	<u>National</u>	
Education	Media campaign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	School program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Community safety project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Provider education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Parent education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Public forum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency	New policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Revised policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	New program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	New services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Expanded services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Law	New law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Amended law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Enforcement of law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environment	Modify a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recall a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Modify a public space	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Modify a private space(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:
- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> N/A, no strategies | <input type="checkbox"/> Mental health               | <input type="checkbox"/> Law enforcement  | <input type="checkbox"/> Advocacy organization    | <input type="checkbox"/> Other, specify: |
| <input type="checkbox"/> No one             | <input type="checkbox"/> Schools                     | <input type="checkbox"/> Medical examiner | <input type="checkbox"/> Local community group    |  |
| <input type="checkbox"/> Health department  | <input type="checkbox"/> Hospital                    | <input type="checkbox"/> Coroner          | <input type="checkbox"/> New coalition/task force |  |
| <input type="checkbox"/> Social services    | <input type="checkbox"/> Other health care providers | <input type="checkbox"/> Elected official | <input type="checkbox"/> Youth group              | <input type="checkbox"/> U/K             |

**L. THE REVIEW MEETING PROCESS**

1. Date of first CDR meeting: \_\_\_\_\_
2. Number of CDR meetings for this case: \_\_\_\_\_
3. Is CDR complete?  N/A  Yes  No

4. Agencies at CDR meeting, check all that apply:
- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Medical examiner/coroner     | <input type="checkbox"/> CPS                   | <input type="checkbox"/> Other health care | <input type="checkbox"/> Mental health   | <input type="checkbox"/> Military      |
| <input type="checkbox"/> Law enforcement              | <input type="checkbox"/> Other social services | <input type="checkbox"/> Fire              | <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Others, list: |
| <input type="checkbox"/> Prosecutor/district attorney | <input type="checkbox"/> Physician             | <input type="checkbox"/> EMS               | <input type="checkbox"/> Court           |  |
| <input type="checkbox"/> Public health                | <input type="checkbox"/> Hospital              | <input type="checkbox"/> Education         | <input type="checkbox"/> Child advocate  |  |

<p>5. Were the following data sources available at the CDR meeting?</p> <p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> CDC's SUIDI Reporting Form</li> <li><input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form</li> <li><input type="checkbox"/> Birth certificate - full form</li> <li><input type="checkbox"/> Death certificate</li> <li><input type="checkbox"/> Child's medical records or clinical history, including vaccinations</li> <li><input type="checkbox"/> Biological mother's obstetric and prenatal information</li> <li><input type="checkbox"/> Newborn screening results</li> <li><input type="checkbox"/> Law enforcement records</li> <li><input type="checkbox"/> Social service records</li> <li><input type="checkbox"/> Child protection agency records</li> <li><input type="checkbox"/> EMS run sheet</li> <li><input type="checkbox"/> Hospital records</li> <li><input type="checkbox"/> Autopsy/pathology reports</li> <li><input type="checkbox"/> Mental health records</li> <li><input type="checkbox"/> School records</li> <li><input type="checkbox"/> Substance abuse treatment records</li> </ul>	<p>6. Factors that prevented an effective CDR meeting, check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Confidentiality issues among members prevented full exchange of information</li> <li><input type="checkbox"/> HIPAA regulations prevented access to or exchange of information</li> <li><input type="checkbox"/> Inadequate investigation precluded having enough information for review</li> <li><input type="checkbox"/> Team members did not bring adequate information to the meeting</li> <li><input type="checkbox"/> Necessary team members were absent</li> <li><input type="checkbox"/> Meeting was held too soon after death</li> <li><input type="checkbox"/> Meeting was held too long after death</li> <li><input type="checkbox"/> Records or information were needed from another locality in-state</li> <li><input type="checkbox"/> Records or information were needed from another state</li> <li><input type="checkbox"/> Team disagreement on circumstances</li> <li><input type="checkbox"/> Other factors, specify:</li> </ul>
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<p>7. CDR meeting outcomes, check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review led to additional investigation</li> <li><input type="checkbox"/> Team disagreed with official manner of death. What did team believe manner should be?</li> <li><input type="checkbox"/> Team disagreed with official cause of death. What did team believe cause should be?</li> <li><input type="checkbox"/> Because of the review, the official cause or manner of death was changed</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review led to the delivery of services</li> <li><input type="checkbox"/> Review led to changes in agency policies or practices</li> <li><input type="checkbox"/> Review led to prevention initiatives being implemented</li> </ul> <p style="text-align: right;"> <input type="checkbox"/> Local    <input type="checkbox"/> State    <input type="checkbox"/> National </p>
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8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

**M. SUID AND SDY CASE REGISTRY**

1. Is this an SDY or SUID case?     Yes     No    If no, go to Section N

<p>2. Did this case go to Advance Review for the SDY Case Registry?</p> <p><input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, date of first Advance Review meeting:</p>	<p>3. Notes from Advance Review meeting:</p>
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4. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary?     Yes     No     U/K

<p>5. Was a specimen sent to the SDY Case Registry bio-repository?</p> <p><input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	<p>6. Did the family consent to the SDY Case Registry?</p> <p><input type="radio"/> N/A    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>
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7. Categorization for SDY Case Registry (choose only one):

<input type="radio"/> Excluded from SDY Case Registry	<input type="radio"/> Explained cardiac	<input type="radio"/> Explained other	<input type="radio"/> Unexplained, SUDEP
<input type="radio"/> No autopsy or death scene investigation	<input type="radio"/> Explained neurological	<input type="radio"/> Unexplained, possible cardiac	<input type="radio"/> Unexplained infant death (under age 1)
<input type="radio"/> Incomplete case information	<input type="radio"/> Explained infant suffocation (under age 1)	<input type="radio"/> Unexplained, possible cardiac and SUDEP	<input type="radio"/> Unexplained child death (age 1 and over)

<p>8. Categorization for SUID Case Registry (choose only one):</p> <ul style="list-style-type: none"> <li><input type="radio"/> Excluded (other explained causes, not suffocation)</li> <li><input type="radio"/> Unexplained: No autopsy or death scene investigation</li> <li><input type="radio"/> Unexplained: Incomplete case information</li> <li><input type="radio"/> Unexplained: No unsafe sleep factors</li> <li><input type="radio"/> Unexplained: Unsafe sleep factors</li> <li><input type="radio"/> Unexplained: Possible suffocation with unsafe sleep factors</li> <li><input type="radio"/> Explained: Suffocation with unsafe sleep factors</li> </ul>	<p>If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Soft bedding</li> <li><input type="checkbox"/> Wedging</li> <li><input type="checkbox"/> Overlay</li> <li><input type="checkbox"/> Other, specify:</li> </ul>
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**N. 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, 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?

**O. FORM COMPLETED BY:**

PERSON:

EMAIL:

TITLE:

DATE COMPLETED:

AGENCY:

DATA ENTRY COMPLETED FOR THIS CASE?

PHONE:

**For State Program Use Only:**  
DATA QUALITY ASSURANCE COMPLETED BY STATE



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Data Entry: <https://cdrdata.org>  
[www.childdeathreview.org](http://www.childdeathreview.org)  
For help, email: [info@childdeathreview.org](mailto:info@childdeathreview.org)  
1-800-656-2434