



Sudden Unexpected Infant Death Investigation Reporting Form

For use during the investigation of infant (under 1 year of age) deaths that are sudden, unexpected, and unexplained prior to investigation.

INFANT DEMOGRAPHICS

1. **Infant information.** Full name: _____ Date of birth: (mm/dd/yyyy) _____
Age: _____ SS#: _____ Case number: _____
Primary residence address: _____
City: _____ State: _____ Zip: _____
2. Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other
3. Sex: Male Female

PREGNANCY HISTORY

1. **Birth mother information.** Unavailable Full name: _____
Maiden name: _____ Date of birth: (mm/dd/yyyy) _____ SS#: _____
Current address: _____
Same as infant's primary residence address above City: _____
State: _____ Zip: _____ Email address: _____
2. How long has the birth mother been at this address? Years: _____ Months: _____ Days: _____
3. Previous address(es) (cities/counties/states) in the past 5 years:

4. Did the birth mother receive prenatal care? Yes No Unknown
If yes: At how many weeks or months did prenatal care begin? _____ Weeks _____ Months
How many prenatal care visits were completed? _____
5. Where did the birth mother receive prenatal care? Physician/Provider: _____
Hospital or Clinic: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
6. Did the birth mother have any complications, medical conditions, or injuries during her pregnancy?
(e.g., high blood pressure, bleeding, gestational diabetes, fall, or accident) Yes No Unknown
If yes, describe:

7. During her pregnancy, did the birth mother use any of the following?

Substance	Use			Specify Type	Frequency
Over the counter medications	Yes	No	Unknown		
Prescribed medications	Yes	No	Unknown		
Herbal remedies	Yes	No	Unknown		
Alcohol	Yes	No	Unknown		
Illicit drugs (e.g., heroin)	Yes	No	Unknown		
Tobacco (e.g., cigarettes or e-cigarettes)	Yes	No	Unknown		
Other	Yes	No	Unknown		

INFANT HISTORY

1. Source of infant medical history information. (check all that apply)

Doctor
 Other health care provider
 Medical record
 Parent or primary caregiver
 Other family member

Other, specify: _____

2. Were there any complications during delivery or at birth? (e.g., emergency C-section, or infant needed oxygen)

Yes
 No
 Unknown
 If yes, describe: _____

3. Did the infant have abnormal newborn screening results? Yes No Unknown

If yes, describe: _____

4. Infant's length at birth: _____ IN CM

5. Infant's weight at birth: _____ LBS and OZ GM

6. Compared to the due date, when was the infant born?

Early (before 37 weeks)
 Late (after 41 weeks)
 On time
 How many weeks? _____
 Infant's due date: (mm/dd/yyyy) _____

7. Was the infant a singleton or multiple birth? Singleton Twin Triplet Quadruplet or higher

8. Was the infant born with Neonatal Abstinence Syndrome (NAS)? (NAS is a drug withdrawal syndrome in newborns exposed to substances, like opioids, before birth) Yes No Unknown

If yes, did the infant need pharmacologic treatment? Yes No Unknown

9. Fill out the contact information for the infant's regular pediatrician and birth hospital.

Item	Regular Pediatrician	Birth Hospital
Date	Of last visit: _____	Of discharge: _____
Name of hospital or clinic		
Address		
Phone number		

10. Describe the two most recent times the infant was seen by a health care provider.

(include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls)

Visit type	1 st most recent visit	2 nd most recent visit
Reason for visit		
Action taken		
Date		
Physician's name		
Hospital or clinic		
Address		
Phone number		

11. Did the infant have any of the following?

Symptom	Within 72 hrs of incident		
Fever	Yes	No	Unknown
Cough	Yes	No	Unknown
Diarrhea	Yes	No	Unknown
Excessive sweating	Yes	No	Unknown
Stool changes	Yes	No	Unknown
Lethargy or sleeping more than usual	Yes	No	Unknown
Difficulty breathing	Yes	No	Unknown
Fussiness or excessive crying	Yes	No	Unknown
Exposure to anyone who was sick <i>(e.g., at home or at daycare)</i>	Yes	No	Unknown
Decrease in appetite	Yes	No	Unknown
Falls or injuries	Yes	No	Unknown
Other, specify: _____	Yes	No	Unknown

Symptom	Within 72 hrs of incident			At any time		
Allergies or allergic reactions <i>(food, medication, or other)</i>	Yes	No	Unknown	Yes	No	Unknown
Abnormal growth, weight gain, or weight loss	Yes	No	Unknown	Yes	No	Unknown
Apnea <i>(stopped breathing)</i>	Yes	No	Unknown	Yes	No	Unknown
Cyanosis <i>(turned blue or gray)</i>	Yes	No	Unknown	Yes	No	Unknown
Seizures or convulsions	Yes	No	Unknown	Yes	No	Unknown
Cardiac <i>(heart)</i> abnormalities	Yes	No	Unknown	Yes	No	Unknown
Colic <i>(frequent prolonged crying/chronic inconsolable fussiness)</i>	Yes	No	Unknown	Yes	No	Unknown
Feeding issues <i>(e.g., reflux)</i>	Yes	No	Unknown	Yes	No	Unknown
Vomiting	Yes	No	Unknown	Yes	No	Unknown
Choking	Yes	No	Unknown	Yes	No	Unknown
Other, specify: _____	Yes	No	Unknown	Yes	No	Unknown

If yes to any of the above, describe:

12. Infant exposed to second hand smoke? (*environmental tobacco smoke*) Yes No Unknown
 If yes, how often? Frequently (*several times a week*) Occasionally (*several times a month*) Unknown

13. In the 72 hours before death, was the infant given any vaccinations or medications? (*include any home remedies, herbal medications, prescription medications, over-the-counter medications*)

Vaccine or medication name	Dose last given	Date given (mm/dd/yy)	Approx. time given	Reasons given or comments

14. Was the infant last placed to sleep with a bottle? Yes No Unknown
 If yes, was the bottle propped? (*object used to hold bottle while infant feeds*) Yes No Unknown

If yes: What object propped the bottle? _____

Could the infant hold the bottle? Yes No Unknown

15. Who was the last person to feed the infant? (*name and familial relationship to infant*)

16. Did the death occur during feeding? Breastfeeding Bottle-feeding Eating solids Not during feeding

17. Was the infant ever breastfed? Yes No Unknown If yes, for how many months? _____

18. What did the infant consume in the 24 hours prior to death?

Consumed?	If yes, describe	If yes, newly introduced?			If yes, was this the last thing consumed prior to incident?		If last fed, indicate quantity	If last fed, indicate date and time?
Breastmilk		Yes	No	Unknown	Yes	No		
Formula		Yes	No	Unknown	Yes	No		
Water		Yes	No	Unknown	Yes	No		
Other liquids		Yes	No	Unknown	Yes	No		
Solids		Yes	No	Unknown	Yes	No		
Other		Yes	No	Unknown	Yes	No		

19. Among the infant's blood relatives (*siblings, parents, grandparents, aunts, uncles, or first cousins*) was there any...
 Sudden or unexpected death before the age of 50? Yes No Unknown

Heart disease? (*e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia*)
 Yes No Unknown

If yes to either, describe: (*include relation to infant*) _____

20. Did the infant have any birth defect(s)? Yes No Unknown

If yes, describe: _____

21. Was the infant able to roll over on his or her own? (*check all that apply*) Front to back Back to front

22. Indicate the infant's ability to lift or hold his or her head up. Unable 1 second 5 seconds ≥10 seconds Unknown

23. Was the infant meeting or not meeting growth and developmental milestones? (*e.g., sitting up, crawling, rolling over, or feeding well. Include if the caregiver, supervisor, or medical professional had any concerns.*)

24. Is there anything else that may have affected the infant that has not yet been documented? (*e.g., exposed to fumes, infant unusually heavy, placed with positional support or wedge, or international travel*)

INCIDENT SCENE INVESTIGATION

1. Incident scene (*place infant found unresponsive or dead*). **Type of location?** (*e.g., primary residence, daycare, or grandmother's house*)

Address: _____ City: _____
 State: _____ Zip: _____

2. Was the infant in a new or different environment? (*not part of the infant's normal routine*) Yes No Unknown

If yes, describe: _____

3. Did the death occur at a daycare? Yes No Unknown

If yes: How many children younger than 18 years of age were under the care of the provider at the time of the incident?

(*including their own children*) _____

How many adults aged 18 years or older were supervising the child(ren)? _____

How long has the daycare been open for business? _____

Is the daycare licensed? Yes No Unknown

If yes: License number? _____ *Licensing agency?* _____

4. How many people live at the incident scene? **Children** (*younger than 18 years*) _____ **Adults** (*18 years or older*) _____

5. What kind of heating or cooling sources were being used at the incident scene? (*e.g., A/C window unit, wood-burning fireplace, or open window*)

6. Was there a working carbon monoxide (CO) alarm at the incident scene? Yes No Unknown

7. Indicate the temperature of the room where the infant was found unresponsive, and the surrounding area. (*fill in temperatures*)

Thermostat setting: _____ Thermostat reading: _____ Incident room: _____ Outside: _____ Time of reading: _____

8. Which of these devices were operating in the room where the infant was found unresponsive? (*check all that apply*)

Fan Apnea monitor Humidifier Vaporizer Air purifier None Unknown

Other, specify: _____

9. What was the source of drinking water at the incident scene? (*check all that apply*)

Public or municipal water Bottled water Well water Unknown

Other, specify: _____

10. Which of the following were present at the incident scene? *(check all that apply)*

Insects Mold growth Smokey smell Pets Dampness Peeling paint Visible standing water

Presence of alcohol containers Rodents or vermin None

Odors or fumes, describe: _____

Presence of prescription drugs, describe: _____

Presence of illicit drugs or drug paraphernalia, describe: _____

Other, describe: _____

11. Describe the general appearance of incident scene. *(e.g., cleanliness, hazards, or overcrowding)*

12. Is there anything else that may have affected the infant that has not yet been documented? *(e.g., drug or alcohol use at scene, history of domestic violence, or child abuse or neglect)*

INCIDENT CIRCUMSTANCES

1. Who was the usual caregiver(s)? *(name(s) and familial relationship to infant)* _____

2. Who was the caregiver(s) at the time of the incident? *(name(s) and familial relationship to infant)*

3. Who found the infant unresponsive? *(If caregiver is same as birth mother Skip question #3)*

Full name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of birth: _____

Email address: _____ Phone number: _____

Work address: _____

Familial relationship to infant? *(e.g., birth mother, grandfather, or adoptive or foster parent)*

4. Describe what happened. *(include details about how the infant was found)*

5. Was there anything different about the infant in the last 24 hours? Yes No Unknown

If yes, describe:

6. What was the temperature in the incident room? Hot Cold Normal Other

7. Was there a crib, bassinet, or portable crib at the place of incidence? Yes No Unknown

If yes, was it in good or usable condition? (e.g., not broken or not full of laundry) Yes No Unknown

If no, explain:

8. Where was the infant (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed? (*write P, L, F, or U, leave blank if none*)

- | | | | | |
|--|--|--|-----------------------------------|---|
| <input type="checkbox"/> Crib | <input type="checkbox"/> Portable Crib | <input type="checkbox"/> Waterbed | <input type="checkbox"/> Stroller | <input type="checkbox"/> Playpen/play area (<i>not portable crib</i>) |
| <input type="checkbox"/> Bassinet | <input type="checkbox"/> Sofa/couch | <input type="checkbox"/> Swing | <input type="checkbox"/> Futon | <input type="checkbox"/> Bouncy chair |
| <input type="checkbox"/> Bedside sleeper | <input type="checkbox"/> Chair | <input type="checkbox"/> Baby box | <input type="checkbox"/> Floor | <input type="checkbox"/> Rocking sleeper |
| <input type="checkbox"/> Car seat | <input type="checkbox"/> Unknown | <input type="checkbox"/> Held in person's arms | <input type="checkbox"/> | <input type="checkbox"/> In-bed sleeper |

Other, specify: _____

Adult bed — *If yes, what type?* Twin Full Queen King Unknown

Other, specify: _____

9. Describe the condition and firmness of the surface where the infant was found.

10. Was the infant wrapped or swaddled? Yes No Unknown

If yes: Describe the arm position. Arms free and out Arms in One arm in and one arm out

Describe swaddle. (*include blanket type and tightness*) _____

11. What was the infant wearing? (*e.g., t-shirt or disposable diaper*) _____

12. What was the infant's usual sleep position? Sitting Back Stomach Side Unknown

13. Describe the circumstances of infant when last placed by caregiver, last known alive, and found.

	Placed	Last known alive	Found
Date			
Time			
Location (<i>e.g., living room or bedroom</i>)			
Position (<i>e.g., sitting, back, stomach, side, or unknown</i>)			
Face position (<i>e.g., down, up, left, right, or unknown</i>)			
Neck position (<i>e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned</i>)			

14. Was the infant's airway obstructed by a person or object when found? (*includes obstruction of the mouth or nose, or compression of the neck or chest*)

Unobstructed Fully obstructed Partially obstructed Unknown

If fully or partially, what was obstructed or compressed? (check all that apply) Nose Mouth Chest Neck

15. Indicate the items present in the sleep environment and their positional relation to the infant when the infant was found.

Item	Present?			If yes, position in relation to infant?				If yes, did object obstruct the infant's mouth, nose, chest, or neck?		
	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Adult(s) (18 years or older)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Other child(ren) (younger than 18 years)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Animal(s)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Mattress	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Comforter, quilt or other	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Fitted sheet	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Thin blanket	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Pillow(s)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Cushion	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Nursing or u-shaped pillow	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Sleep positioner (wedge)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Bumper pads	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Clothing (not on a person)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Crib railing or side	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Wall	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Toy(s)	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown
Other, specify: _____	Yes	No	Unknown	Over	Under	Next to	Unknown	Yes	No	Unknown

If yes to adult(s) or child(ren) sharing sleep surface with the infant, complete table below. NA

Name of individual(s) sharing sleep surface with infant	Relationship to infant	Age	Height	Weight	Impaired by drugs or alcohol?			Fell asleep feeding infant?		
					Yes	No	Unknown	Yes	No	Unknown
					Yes	No	Unknown	Yes	No	Unknown
					Yes	No	Unknown	Yes	No	Unknown
					Yes	No	Unknown	Yes	No	Unknown

If yes to impaired, describe: _____

16. Were there any secretions present at the scene? Yes No Unknown

If yes, describe: (include where they were found)

17. Was there evidence of wedging? (wedging is an obstruction of the nose or mouth, or compression of the neck or chest as a result of being stuck or trapped between inanimate objects) Yes No Unknown

If yes, describe: _____

18. Was there evidence of overlay? (overlay is an obstruction of the nose or mouth, or compression of the neck or chest as a result of a person rolling on top of or against an infant) Yes No Unknown

If yes, describe: _____

19. Was the infant breathing when found? Yes No Unknown

If no, did anyone witness the infant stop breathing? Yes No Unknown

20. Describe the infant's appearance when found. (*indicate all that apply*)

Appearance	Present?			Describe and specify location
Discoloration around face, nose, or mouth	Yes	No	Unknown	
Secretions or fluids (<i>e.g., foam, froth, or urine</i>)	Yes	No	Unknown	
Skin discoloration (<i>e.g., livor mortis, pale areas, darkness, or color changes</i>)	Yes	No	Unknown	
Pressure marks (<i>e.g., pale areas, or blanching</i>)	Yes	No	Unknown	
Rash or petechiae (<i>e.g., small, red blood spots on skin, membrane, or eyes</i>)	Yes	No	Unknown	
Marks on body (<i>e.g., scratches or bruises</i>)	Yes	No	Unknown	
Other: _____	Yes	No	Unknown	

21. What did the infant feel like when found? (*check all that apply*)

Sweaty Warm to touch Cool to touch Limp/flexible Rigid/stiff Unknown

Other, specify: _____

22. Did EMS respond? Yes No Unknown

If yes, was the infant transported? Yes No Unknown

23. Was resuscitation attempted? Yes No Unknown

If yes: By whom? (e.g., EMS, bystander, or parent) _____

Date: (*mm/dd/yyyy*) _____ Time: _____ Type of compression? (*check all that apply*)

Was rescue breathing done? Yes No Unknown Two finger One hand Two hands

The following questions refer to the caregiver(s) at the time of death.

24. Has the caregiver ever had a child under their care die suddenly and unexpectedly? Yes No Unknown

If yes, explain: (include familial relationship of child and infant, and cause of death)

25. Were the infant and caregiver in the *same room* at the time of the incident, but not sharing the same sleep surface?

Yes No Unknown N/A - sharing a sleep surface

26. Was the infant's caregiver using any of the following during the incident? (*indicate all that apply*)

Substance	Caregiver used?			Frequency
Over the counter medications	Yes	No	Unknown	
Prescription medications	Yes	No	Unknown	
Opioids	Yes	No	Unknown	
Tobacco, specify: (<i>e.g., cigarettes or e-cigarettes</i>)	Yes	No	Unknown	
Alcohol	Yes	No	Unknown	
Herbal remedies	Yes	No	Unknown	
Other, specify:	Yes	No	Unknown	

Was the infant's caregiver asked to consent to blood or urine for drug/alcohol testing? Yes No Unknown

If yes, what were the results? _____

INVESTIGATION SUMMARY

1. Arrival dates and times.

Person(s) involved	Hospital	Incident scene
Infant		N/A
Law enforcement		
Death investigator		

2. Agencies conducting an investigation? *(check all that apply)* Child protective services
 Death investigator from medical examiner or coroner office Law enforcement, specify: _____
 Other, specify: _____

3. Indicate when the form was completed. Date: *(mm/dd/yyyy)* _____ Time: _____

4. If more than one person was interviewed, does the information provided differ? Yes No N/A
 If yes, detail any differences or inconsistencies of relevant information. *(e.g., placed on sofa or last known alive on chair)*

5. Indicate the task(s) performed. *(check all that apply)* Additional scene(s) *(forms attached)* conducted Photos or video taken
 Materials collected or evidence logged Next of kin notified 911 tape obtained EMS run sheet or report obtained
 Witness(es)/caregiver(s) interviewed

6. Was the family offered grief counseling services? Yes No Unknown

7. Was a doll scene reenactment performed? Yes No Unknown

If no, why? _____

If yes: How was it documented? *(check all that apply)* Photographed Videoed Other, specify: _____

Where was it performed? Incident scene Hospital Other, specify: _____

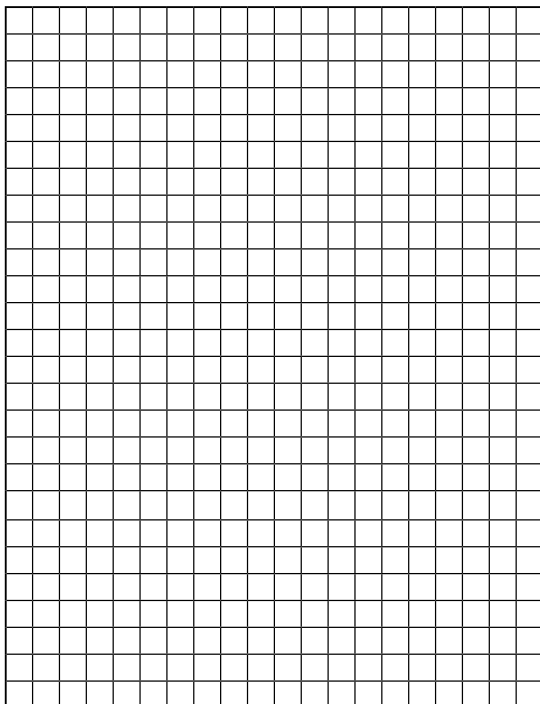
Indicate when the doll reenactment was performed. Date performed: *(mm/dd/yyyy)* _____ Time performed: _____

Were photos provided to the pathologist? Yes No Unknown

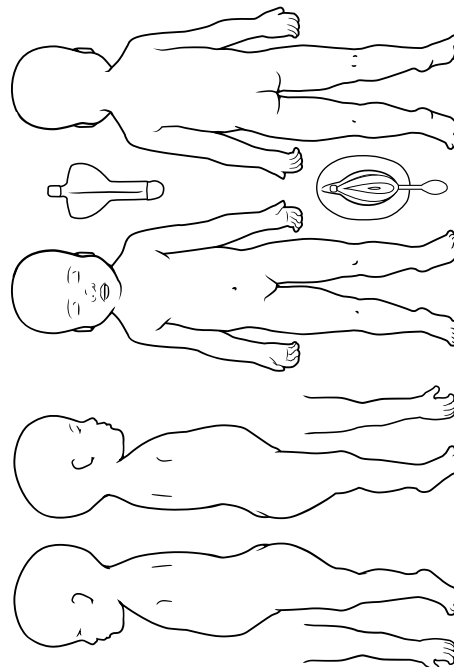
Do the scenarios given during the doll reenactment(s) match what was seen during the preliminary investigation?
 Yes No N/A

INVESTIGATION DIAGRAMS

1. Scene diagram *(illustrate the infant's sleep environment)*



2. Body diagram *(note visible injuries, livor mortis, or rigor mortis)*



3. Scene and doll reenactment photos *(include with form)*

SUMMARY FOR PATHOLOGIST

1. Investigator information. Name: _____ Agency: _____

Phone: _____ Email address: _____

2. Indicate when the investigation took place. Date: *mm/dd/yyyy* _____ Time: _____

3. Indicate when the infant was pronounced dead. Date: *(mm/dd/yyyy)* _____ Time: _____

4. Indicate when it is estimated the infant died. Date: *(mm/dd/yyyy)* _____ Time: _____

5. Location of death: *(e.g., home or hospital)* _____

6. Data sources consulted to complete this form. *(check all that apply)* Infant medical records Birth records Prenatal records

Witness interview Photos/videos from caregivers demonstrating injuries, developmental milestone, or medical concerns

Other, specify: _____

7. Indicate whether preliminary investigation suggests any of the following. *(indicate all that apply)*

Sleeping Environment	Yes	No
Asphyxia <i>(e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)</i>		
Sharing of sleep surface with adults, children, or pets		
Change in sleep condition <i>(e.g., unaccustomed stomach sleep position, location, or sleep surface)</i>		
Hyperthermia or hypothermia <i>(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)</i>		
Environmental hazards <i>(e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)</i>		
Unsafe sleep condition <i>(e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)</i>		

Infant History	Yes	No
Diet <i>(e.g., solids introduced)</i>		
Recent hospitalization		
Previous medical diagnosis		
History of acute life threatening events <i>(e.g., apnea, seizures, or difficulty breathing)</i>		
History of medical care without diagnosis		
Recent fall or other injury		
History of religious, cultural or alternative remedies		
Cause of death due to natural causes other than SIDS <i>(e.g., birth defects or complications of preterm birth)</i>		

Family Information	Yes	No
Prior sibling deaths		
Sudden or unexpected death before the age of 50 or heart disease <i>(e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia)</i> among the infant's blood relatives <i>(e.g., siblings, parents, grandparents, aunts, uncles, or first cousins)</i>		
Previous encounters with police or social service agencies		
Request for tissue or organ donation		
Objection to autopsy		

Exam	Yes	No
Preterminal resuscitative treatment		
Signs of trauma or injury, poisoning, or intoxication		

Other	Yes	No
Suspicious circumstances		
Other alerts for pathologist's attention		

If yes to any of the above, explain in detail: (description of circumstances)

8. Medical examiner or pathologist information.

Name: _____

Agency: _____

Phone: _____ **Fax:** _____ **Email address:** _____

Visit <https://www.cdc.gov/sids/SUIDRF.htm> for Additional Investigative Scene Forms of Body Diagram, EMS Interview, Hospital Interview, Immunization Record, Infant Exposure History, Informant Contact, Law Enforcement Interview, Materials Collection Log, Non Professional Responder Interview, Parental Information, Primary Residence Investigation, and Scene Diagram.