



FIMR Report Form
National Fatality Review
Case Reporting System

Version 5.0



Data entry website: <https://data.ncfrp.org>

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www.ncfrp.org

SAVING LIVES TOGETHER

Instructions:

This case report is used by Fetal and Infant Mortality Review (FIMR) teams to enter data into the National Fatality Review Case Reporting System (NFR-CRS). The NFR-CRS is available to states and local sites from the National Center for Fatality Review & Prevention (NCFRP) and requires a data use agreement for data entry. The purpose is to collect comprehensive information from multiple agencies participating in a review. The NFR-CRS documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the team to prevent other deaths.

While this data collection form is an important part of the FIMR process, it should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step-by-step manner as part of the team discussion.

It is not expected that teams will have answers to all of the questions. However, over time abstractors and teams begin to understand the importance of data collection and will make efforts to incorporate necessary information into the case summary. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form.

The NFR-CRS Data Dictionary is available. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

The form contains three types of questions: (1) select one response as represented by a circle; (2) select multiple responses as represented by a square; and (3) free text responses. This last type is indicated by the words "specify" or "describe."

Many teams ask what is the difference between leaving a question blank and selecting the response "unknown." A question should be marked "unknown" if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. "N/A" stands for "not applicable" and should be used if the question does not apply.

HIPAA Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields**, do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital."

Why this reminder? Text fields may be shared with approved researchers as noted in our Data Use Agreements. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP.

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"/> Language barriers	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> Didn't think she was pregnant
<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Couldn't get provider to take as patient	<input type="checkbox"/> Services not available	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Distrust of health care system	
<input type="checkbox"/> No phone	<input type="checkbox"/> Couldn't get an earlier appointment	<input type="checkbox"/> Unwilling to obtain care	<input type="checkbox"/> U/K
<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Didn't know where to go	
44. Did the mother experience any medical complications in previous pregnancies? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:			
<input type="checkbox"/> Previous preterm birth	<input type="checkbox"/> Previous small for gestational age		
<input type="checkbox"/> Previous low birth weight birth	<input type="checkbox"/> Previous large for gestational age (greater than 4000 grams)		
45. Did the mother use any medications, drugs or other substances during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:			
<input type="checkbox"/> Over-the-counter meds	<input type="checkbox"/> Anti-epileptic	<input type="checkbox"/> Nausea/vomiting medications	<input type="checkbox"/> Cocaine
<input type="checkbox"/> Allergy medications	<input type="checkbox"/> Anti-hypertensives	<input type="checkbox"/> Cholesterol medications	<input type="checkbox"/> Heroin
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Anti-hypothyroidism	<input type="checkbox"/> Sleeping pills	<input type="checkbox"/> Marijuana
<input type="checkbox"/> Anti-flu/antivirals	<input type="checkbox"/> Arthritis medications	<input type="checkbox"/> Meds to treat preterm labor	<input type="checkbox"/> Methamphetamine
<input type="checkbox"/> Anti-depressants/anti-anxiety/anti-psychotics	<input type="checkbox"/> Diabetes medications	<input type="checkbox"/> Meds used during delivery	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Asthma medications	<input type="checkbox"/> Progesterone/P17	<input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome?	<input type="checkbox"/> U/K
If any item is checked, please indicate the generic or brand name of the medications or drugs:			
46. Was the infant born drug exposed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
47. Did the infant have neonatal abstinence syndrome (NAS)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
48. Level of birth hospital: <input type="radio"/> 1° <input type="radio"/> 2° <input type="radio"/> 3° <input type="radio"/> Free-standing birth hospital <input type="radio"/> Home birth <input type="radio"/> Other, specify: <input type="radio"/> U/K		49. At discharge from the birth hospital, was a case manager assigned to the mother? <input type="radio"/> N/A, mother did not go to a birth hospital <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
		50. Did the mother attend a postpartum visit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
		51. Did the infant have a NICU stay of more than one day? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, for what reason(s)? Check all that apply:	
		<input type="checkbox"/> Prematurity	<input type="checkbox"/> Apnea
		<input type="checkbox"/> Low birth weight	<input type="checkbox"/> Sepsis
		<input type="checkbox"/> Tachypnea	<input type="checkbox"/> Feeding difficulties
		<input type="checkbox"/> Drug/alcohol exposure	<input type="checkbox"/> Hypothermia
		<input type="checkbox"/> Anemia	<input type="checkbox"/> Meconium aspiration
		<input type="checkbox"/> Jaundice	<input type="checkbox"/> Congenital anomalies
		<input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K
52. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> Yes If yes, ___ Avg # cigarettes/day <input type="radio"/> No (20 cigarettes in pack) <input type="radio"/> U/K <input type="checkbox"/> U/K quantity		53. Did the mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
		<u>Trimester 1</u> <u>Trimester 2</u> <u>Trimester 3</u>	
		If yes, _____ Avg # cigarettes/day <input type="checkbox"/> U/K quantity	
54. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:		55. Did the mother have postpartum depression? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
If this was a fetal death, go to Section A4.			
56. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, any breast milk at 3 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, any breast milk at 6 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If ever, was infant receiving breast milk at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		57. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe any abnormality such as a fatty acid oxidation error:	
If the infant never left the hospital following birth, go to Section A4.			
58. 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"/> None <input type="checkbox"/> Cyanosis <input type="checkbox"/> Infection <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Allergies <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Other, specify: <input type="checkbox"/> Apnea <input type="checkbox"/> U/K		59. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Vomiting <input type="checkbox"/> Cyanosis <input type="checkbox"/> Fever <input type="checkbox"/> Choking <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other, specify: <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Stool changes <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> U/K <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Apnea	
60. 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:	61. 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:	62. 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:	63. 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

A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR

64. Mother's name First: _____ Middle: _____ Last: _____ Maiden: _____ U/K

65. Father's name: First: _____ Middle: _____ Last: _____ U/K

66. Mother's country of birth: _____ U/K 67. Father's country of birth: _____ U/K

68. Mother's residence address: Same as child U/K
 Street: _____ Apt. _____
 City: _____
 State: _____ Zip: _____ County: _____

69. Mother's marital status during pregnancy:
 Single Separated
 Married Widowed
 Divorced U/K

70. Number of months between prior pregnancy and this one: _____ U/K

71. Was mother taking folic acid or a multivitamin prior to this pregnancy?
 Yes No U/K

72. Mother's employment during pregnancy:
 Employed If employed, did she think it was physically hard? Yes No U/K
 Unemployed
 Student If employed, did she think the job was stressful? Yes No U/K
 On disability Yes No U/K
 Stay-at-home If employed or student, number of weeks post-delivery started or returned: _____
 U/K If employed or student, who watched the infant? Describe: _____

73. Mother's pre-pregnancy weight, height, BMI:
 Weight in pounds (whole number): _____ lbs U/K
 Height in feet and inches (whole numbers): _____ ft _____ in U/K
 BMI will be calculated automatically if both height and weight are available.
 If you don't have height and weight but know the mother's prepregnancy BMI, you can enter it: _____

74. Mother's pregnancy weight gain or loss in pounds (whole number)
 Enter a negative number for weight loss: _____ lbs U/K

75. Did mother achieve the recommended weight gain? Yes No U/K

76. Mother's age at first pregnancy: _____ U/K

77. For each previous pregnancy, describe most recent first: _____ N/A

Preg #	# in gest. (twins=2)	Baby A, B, C, etc	Year of Delivery	Maternal Age	Gestational age in weeks	Birth weight (grams)	Choose one:				Outcome Code*
							NSVD	C-Sec	VBAC	Other	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	

*Outcome Codes
 1 - Full-term, live birth
 2 - Premature live birth
 3 - Stillbirth > or = 20 weeks
 4 - Spontaneous abortion/miscarriage / Stillbirth < 20 weeks
 5 - Therapeutic abortion
 6 - Voluntary abortion
 7 - Ectopic
 9 - U/K

78. Was mother using birth control in the 3 months prior to this pregnancy? Yes No U/K

If yes, what type?
 LARC including implants/IUDs Natural, withdrawal, pull out rhythm method
 Oral contraceptives, specify: _____
 Barrier methods (male/female condoms/cervical cap) Tubal ligation
 Injections (Depo Provera) Multiple methods
 Spermicides Other, specify: _____
 U/K

If no, was pregnancy: Unintended Intended Mistimed U/K

79. Where was prenatal care most frequently provided for this pregnancy?
 Private provider's office
 County or city health department
 Clinic
 Managed care organization
 Community/neighborhood health center
 Other, specify type: _____
 U/K

80. Which type of provider most frequently provided prenatal care for this pregnancy?
 Nurse practitioner
 OB
 Nurse midwife
 Perinatologist
 Family physician
 Other, specify type: _____
 U/K

81. Was this pregnancy a result of assisted reproductive technology? Yes No U/K

If yes, describe: _____

82. Which of the following tests were performed during this pregnancy?

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

83. During this pregnancy and including any previous pregnancies, did the mother have any medical conditions/complications? Yes No U/K

Timeframe	Referrals during this pregnancy
1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy	1 - No referral, not needed 2 - No referral, already in care 3 - No referral, needed 4 - Referral made, no follow through by mother
2 - Began previous to this pregnancy AND includes current pregnancy	5 - Referral made, mother followed through 9 - U/K
3 - Began during this current pregnancy	
9 - U/K	

If yes, check all that apply:

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

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

If yes, what precautions?

- Took medicine to prevent labor or miscarriage
- Got hormone shots
- Stopped or limited sex during pregnancy
- Used condoms to prevent infection
- Doctor sewed the cervix closed (cerclage of incompetent cervix)
- Had bed rest for one or more weeks at home
 - Was mother able to comply? Yes No U/K
- Was hospitalized for one or more nights
- Reduced work hours or stopped working earlier than expected
- Reduced housework or other physical activities
- Other, specify:

85. Type of delivery:

- | | |
|---|--|
| <input type="checkbox"/> Routine | If C-Section, why was it done? |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Failure to progress |
| <input type="checkbox"/> Normal spontaneous vaginal delivery (NSVD) | <input type="checkbox"/> Fetal distress |
| <input type="checkbox"/> Vaginal, induced or augmented | <input type="checkbox"/> Macrosomia |
| <input type="checkbox"/> Vaginal delivery after C-Section (VBAC) | <input type="checkbox"/> Placental abruption |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Placental Previa |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Malpresentation |
| <input type="checkbox"/> Vacuum extraction | <input type="checkbox"/> Repeat C-Section |
| <input type="checkbox"/> U/K | <input type="checkbox"/> Other, specify: |
| | <input type="checkbox"/> U/K |

<p>86. Were there any signs of fetal distress? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>89. Was there evidence of injury at death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, what type(s) of injury?</p> <p><input type="checkbox"/> Contusion/bruises <input type="checkbox"/> Abrasions/scratches</p> <p><input type="checkbox"/> Fractures <input type="checkbox"/> Resuscitative marks</p> <p><input type="checkbox"/> Cigarette burns <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Hemorrhage</p>	<p>90. Was a placental pathology performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe findings:</p>																																							
<p>87. Were any birth defects noted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>92. Did the mother have stable housing during the pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, indicate the type(s) of instability:</p> <p><input type="checkbox"/> Mother in jail</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Eviction(s)</p> <p><input type="checkbox"/> More than 3 moves in past year</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>																																								
<p>88. Date of mother's discharge from the birth hospital: <input type="radio"/> N/A <input type="radio"/> U/K</p> <p>____/____/____</p> <p>mm / dd / yyyy</p>																																									
<p>91. Payer source for mother's care for the following timeframes (check all that apply):</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Pre</th> <th style="text-align: center;">Preg</th> <th style="text-align: center;">L&D</th> <th style="text-align: center;">Post</th> </tr> </thead> <tbody> <tr> <td>None</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Private insurance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Medicaid</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>State plan</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Indian Health Service</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other, specify:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>U/K</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Pre	Preg	L&D	Post	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Private insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	State plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>93. Did the mother have phone service during the pregnancy?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Rarely</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Most of the time</p> <p><input type="radio"/> Always</p> <p><input type="radio"/> U/K</p>
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<p>94. Did the mother have any high-risk prenatal/antepartum encounters? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, number of visits with primary care provider: _____</p> <p>If yes, number of L&D/triage/ED visits, excluding the birth: _____</p>	<p>95. Did the mother have any hospitalizations greater than 24 hours prior to labor and delivery excluding the birth? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, what treatment was recommended?</p>																																								
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<p>98. Were any infant safety topics discussed at any time between the first prenatal care visit and mother's discharge from the birth hospital? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which topic(s)?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Bath safety</td> <td><input type="checkbox"/> Maternal signs/symptoms that warrant medical attention</td> <td><input type="checkbox"/> Abusive Head Trauma/Shaken Baby Syndrome</td> <td><input type="checkbox"/> Use of infant car seat</td> </tr> <tr> <td><input type="checkbox"/> Infant care</td> <td><input type="checkbox"/> Parenting skills</td> <td><input type="checkbox"/> SUID/Safe Sleep education</td> <td><input type="checkbox"/> Where to go for care in case of infant emergency</td> </tr> <tr> <td><input type="checkbox"/> Infant signs/symptoms that warrant medical attention</td> <td><input type="checkbox"/> Protection from falls</td> <td><input type="checkbox"/> Small object avoidance</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Use of home smoke detector</td> <td></td> </tr> </table>			<input type="checkbox"/> Bath safety	<input type="checkbox"/> Maternal signs/symptoms that warrant medical attention	<input type="checkbox"/> Abusive Head Trauma/Shaken Baby Syndrome	<input type="checkbox"/> Use of infant car seat	<input type="checkbox"/> Infant care	<input type="checkbox"/> Parenting skills	<input type="checkbox"/> SUID/Safe Sleep education	<input type="checkbox"/> Where to go for care in case of infant emergency	<input type="checkbox"/> Infant signs/symptoms that warrant medical attention	<input type="checkbox"/> Protection from falls	<input type="checkbox"/> Small object avoidance	<input type="checkbox"/> Other, specify:			<input type="checkbox"/> Use of home smoke detector																								
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99. Did the mother experience any stressors during her pregnancy? Yes No U/K

If yes, which one(s)?

A close family member was very sick

Separated or divorced from her husband/partner

Husband/partner lost his job

She and her husband/partner argued more than usual

Her husband/partner said he did not want her to be pregnant

Financial problems

Involved in a physical fight

She or her husband/partner went to jail

Someone very close to her had a problem with drinking alcohol or drugs

Physical abuse

Sexual abuse

Emotional abuse

Someone very close to her died

Afraid of violence in her neighborhood

Other, specify:

100. Was the mother a victim of intimate partner violence? Yes No U/K

* Referral key:

1 - No referral, not needed	4 - Referral made, no follow up by mother
2 - No referral, already in service	5 - Referral made, mother followed through
3 - No referral, needed	9 - U/K

Mother as victim: Y N U/K Referral*

Preconception

Pregnancy

Postpartum

101. Was the family referred to any health or human services program during or after the pregnancy? Yes No U/K

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

Referral options: 1 - Referral made, no follow through by mother	2 - Referral made, mother followed through	9 - U/K
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Case management Referral: Drug treatment program Referral:

Infant/child health program Referral: Smoking cessation program Referral:

Child Protection Services Referral: Alcohol cessation program Referral:

Legal aid Referral: Housing authority Referral:

Evidence-based home visiting Referral: Shelters Referral:

Family planning Referral: Unemployment assistance Referral:

Mental health service Referral: Homemaker/home health aide Referral:

Infant mental health program Referral: Medicaid Referral:

Genetic evaluation/counseling Referral: WIC Referral:

GED programs Referral: TANF Referral:

Children's Special Health Care Needs services Referral: SNAP Referral:

102. At any time before or during pregnancy or until the infant's death, did the family experience any difficulties in obtaining, communicating, processing, or understanding basic health information and services in order to make informed health decisions? Yes No U/K

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

103. Apgar: 1 min: 5 min: U/K

104. Were neonatal resuscitation measures required or attempted in delivery room? Yes No U/K

If yes, which measure(s)?

Physical stimulation

Intubation

Respiratory or cardiac meds for resuscitation

Oxygen

Other, specify:

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

Normal newborn nursery

Rooming in

Observation/special care nursery (NICU, intensive care or premature nursery)

If yes, admitting diagnosis:

Transferred to another hospital

Other, specify:

U/K

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

If yes, what were they?

<input type="checkbox"/> Perinatal asphyxia	<input type="checkbox"/> Anemia due to fetal hemorrhage	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Birth injury such as bruising, peripheral nerve damage, cephalohematoma, fractures
<input type="checkbox"/> Respiratory distress syndrome	<input type="checkbox"/> Perinatal STI infection	<input type="checkbox"/> Hypotonia	
<input type="checkbox"/> Convulsion	If yes, specify:	<input type="checkbox"/> Temperature instability	If yes, specify:
<input type="checkbox"/> Hypoglycemia (<40)	<input type="checkbox"/> Hemolysis	<input type="checkbox"/> Delayed feeding adequacy	
<input type="checkbox"/> Neonatal sepsis	If yes, due to:	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other, specify:
If yes, specify:	<input type="radio"/> RH <input type="radio"/> ABO <input type="radio"/> Other	If yes, specify highest bilirubin level:	
	If other, specify:		

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

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

If positive, for what?

<input type="checkbox"/> Alcohol, including ethanol and methanol	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Phencyclidine (PCP)
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Marijuana/THC	<input type="checkbox"/> Opiates, codeine, oxycodone	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Methadone	<input type="checkbox"/> Heroin	<input type="checkbox"/> U/K

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

108. Date of infant's last discharge from any hospital: ___/___/___ U/K

109. Total number of days infant hospitalized: U/K

110. Infant's disposition (after birth, from any hospital):
 Home with parents Other, specify: _____ U/K

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

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

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

114. After the infant came home from the hospital after delivery, did s/he have to go back into the hospital overnight for any reason?
 Yes No U/K
 If yes, how many nights was the infant in this hospital?
 Number of nights: _____ U/K
 If yes, how old was the infant when admitted to this hospital for the last time?
 Number of weeks: _____ U/K

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

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

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

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

Who saw infant	Age in months	Why	Recommended treatment

A5. FIMR MATERNAL INTERVIEW

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

117. Does the mother expect to have any more children?
 Yes No U/K
 If yes, how many? _____ U/K
 When: _____ U/K

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

119. How does the mother remember feeling about becoming pregnant?
 Wanted to be pregnant sooner
 Wanted to be pregnant later
 Wanted to be pregnant then
 Didn't want to be pregnant then or at any time in the future
 U/K

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

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

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

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

124. According to the mother, was the infant in the same room with someone who was smoking?
 Yes No U/K
 If yes, number of hours per day, maximum 24: _____

<p>125. According to the mother, did she have a crib, Pack 'n Play, bassinet, bed side sleeper or baby box for the infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how often did the infant sleep in it? <input type="radio"/> Always <input type="radio"/> Usually <input type="radio"/> Half the time <input type="radio"/> Occasionally <input type="radio"/> Never <input type="radio"/> U/K</p> <p>If anything other than "always," describe where else the infant slept:</p>	<p>126. Did the mother feel that her infant was ever treated differently or unfairly in getting services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, for what reasons?</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Race</td> <td><input type="checkbox"/> Marital status</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Culture/ethnic background</td> <td><input type="checkbox"/> Type of insurance</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Citizenship status</td> <td><input type="checkbox"/> Ability to pay</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Race	<input type="checkbox"/> Marital status	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Culture/ethnic background	<input type="checkbox"/> Type of insurance		<input type="checkbox"/> Citizenship status	<input type="checkbox"/> Ability to pay	<input type="checkbox"/> U/K
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<input type="checkbox"/> Citizenship status	<input type="checkbox"/> Ability to pay	<input type="checkbox"/> U/K								

<p>127. How supportive was the father toward the mother during the pregnancy? <input type="radio"/> Not involved <input type="radio"/> Supportive <input type="radio"/> Unsupportive <input type="radio"/> U/K</p>	<p>128. How satisfied was the mother with the father's contribution(s) toward her or the infant's financial support? <input type="radio"/> Very satisfied <input type="radio"/> Somewhat satisfied <input type="radio"/> Not satisfied <input type="radio"/> U/K</p>
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129. Were any of the following identified as psychosocial or lifestyle problems experienced by the mother AT ANY TIME in her life, as a child herself, before or during pregnancy or while the infant was still alive?

<p>Mother as a child: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Housing inadequate/homeless <input type="checkbox"/> Food insecurity <input type="checkbox"/> Mother treated violently <input type="checkbox"/> Parents or caregiver with substance abuse problem <input type="checkbox"/> Parents or caregiver problem drinkers <input type="checkbox"/> Parents or caregiver with mental health problems <input type="checkbox"/> Parental separation or divorce <input type="checkbox"/> Incarcerated household member 	<p>Current (during pregnancy or after the birth): <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Disturbed mother/infant relationship <input type="checkbox"/> Mother-physical/developmental disability <input type="checkbox"/> Husband/partner-physical/developmental disability <input type="checkbox"/> Mother-employment/education needs <input type="checkbox"/> Husband/partner-employment/education needs <input type="checkbox"/> Inadequate support system <input type="checkbox"/> Mother or husband/partner felt "stereotyped" or profiled due to race, gender, class, etc.
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130. Did the mother feel that she was ever treated differently or unfairly in getting services?
 Yes No U/K

If yes, for what reasons?

<input type="checkbox"/> Race	<input type="checkbox"/> Type of insurance
<input type="checkbox"/> Culture/ethnic background	<input type="checkbox"/> Ability to pay
<input type="checkbox"/> Citizenship status	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Marital status	<input type="checkbox"/> U/K

131. During the mother's recent pregnancy, did the mother have others who would have helped her if a problem had come up? (For example, needed a ride to the clinic or needed to borrow money.) Yes No U/K

If yes, describe who would have helped (husband/partner, friend, mother/in-laws, other family, etc.)

132. Did the father experience any stressors during mother's pregnancy?
 Yes No U/K

If yes, which one(s)?

<input type="checkbox"/> Work or employment problems	<input type="checkbox"/> Housing problems	<input type="checkbox"/> Problems with children or other relatives	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Problems with drugs or alcohol	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Problems with the law	
<input type="checkbox"/> Money problems	<input type="checkbox"/> A death in the family	<input type="checkbox"/> Health problems	

If fetal death or the infant never left the hospital following birth, go to Section B

133. Did the infant ever have an illness for which they weren't seen or treated? Yes No U/K

If yes, what were the barriers?

<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Couldn't get provider to take as a patient	<input type="checkbox"/> Distrust of health care system
<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Unwilling to obtain care
<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Couldn't get an earlier appointment	<input type="checkbox"/> Didn't know where to go
<input type="checkbox"/> No phone	<input type="checkbox"/> Lack of child care (other children)	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> U/K
<input type="checkbox"/> Language barriers	<input type="checkbox"/> Services not available	

This space left intentionally blank.

B. BIOLOGICAL PARENT INFORMATION

No information available, go to Section C

<p>1. Parents' race, check all that apply:</p> <table style="width:100%;"> <tr> <td style="width:33%;"><u>Female</u> <input type="checkbox"/> White</td> <td style="width:33%;"><u>Female</u> <input type="checkbox"/> Native Hawaiian</td> </tr> <tr> <td><u>Male</u> <input type="checkbox"/> Black</td> <td><u>Male</u> <input type="checkbox"/> Pacific Islander, specify:</td> </tr> <tr> <td><input type="checkbox"/> Asian, specify:</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> American Indian, Tribe:</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Alaskan Native, Tribe:</td> <td></td> </tr> </table>	<u>Female</u> <input type="checkbox"/> White	<u>Female</u> <input type="checkbox"/> Native Hawaiian	<u>Male</u> <input type="checkbox"/> Black	<u>Male</u> <input type="checkbox"/> Pacific Islander, specify:	<input type="checkbox"/> Asian, specify:	<input type="checkbox"/> U/K	<input type="checkbox"/> American Indian, Tribe:	<input type="checkbox"/> U/K	<input type="checkbox"/> Alaskan Native, Tribe:		<p>2. Parents' Hispanic or Latino origin?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes, specify origin:</td> <td><u>Male</u> <input type="radio"/> Yes, specify origin:</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>3. Parents' age in years at death:</p> <table style="width:100%;"> <tr> <td><u>Female</u> _____ # Years</td> <td><u>Male</u> _____ # Years</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> Yes, specify origin:	<u>Male</u> <input type="radio"/> Yes, specify origin:	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<u>Female</u> _____ # Years	<u>Male</u> _____ # Years	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<p>4. Parents' employment status:</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Employed</td> <td><u>Male</u> <input type="radio"/> Employed</td> </tr> <tr> <td><input type="radio"/> Unemployed</td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/> On disability</td> </tr> <tr> <td><input type="radio"/> Stay-at-home</td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/> Retired</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> Employed	<u>Male</u> <input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> Retired	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>5. Parents' income:</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> High</td> <td><u>Male</u> <input type="radio"/> High</td> </tr> <tr> <td><input type="radio"/> Medium</td> <td><input type="radio"/> Medium</td> </tr> <tr> <td><input type="radio"/> Low</td> <td><input type="radio"/> Low</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> High	<u>Male</u> <input type="radio"/> High	<input type="radio"/> Medium	<input type="radio"/> Medium	<input type="radio"/> Low	<input type="radio"/> Low	<input type="radio"/> U/K	<input type="radio"/> U/K
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<p>6. Parents' education:</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> < High school</td> <td><u>Male</u> <input type="radio"/> < High school</td> </tr> <tr> <td><input type="radio"/> High school</td> <td><input type="radio"/> High school</td> </tr> <tr> <td><input type="radio"/> College</td> <td><input type="radio"/> College</td> </tr> <tr> <td><input type="radio"/> Post graduate</td> <td><input type="radio"/> Post graduate</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> < High school	<u>Male</u> <input type="radio"/> < High school	<input type="radio"/> High school	<input type="radio"/> High school	<input type="radio"/> College	<input type="radio"/> College	<input type="radio"/> Post graduate	<input type="radio"/> Post graduate	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>7. Parents speak and understand English?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>8. Parents first generation immigrant?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes, country of origin:</td> <td><u>Male</u> <input type="radio"/> Yes, country of origin:</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>9. Parents on active military duty?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes, specify branch:</td> <td><u>Male</u> <input type="radio"/> Yes, specify branch:</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> Yes, country of origin:	<u>Male</u> <input type="radio"/> Yes, country of origin:	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<u>Female</u> <input type="radio"/> Yes, specify branch:	<u>Male</u> <input type="radio"/> Yes, specify branch:	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>10. Parents receive social services in the past twelve months?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> WIC</td> <td><input type="checkbox"/> Home visiting, specify:</td> </tr> <tr> <td><input type="checkbox"/> TANF</td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td><input type="checkbox"/> Food stamps/SNAP/EBT</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/> WIC	<input type="checkbox"/> Home visiting, specify:	<input type="checkbox"/> TANF	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Food stamps/SNAP/EBT	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K
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<p>11. Parents have substance abuse history?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr><td><input type="checkbox"/> Alcohol</td><td><input type="checkbox"/> Cocaine</td></tr> <tr><td><input type="checkbox"/> Marijuana</td><td><input type="checkbox"/> Methamphetamine</td></tr> <tr><td><input type="checkbox"/> Opiates</td><td><input type="checkbox"/> Prescription drugs</td></tr> <tr><td><input type="checkbox"/> Over-the-counter</td><td><input type="checkbox"/> Other, specify:</td></tr> <tr><td><input type="checkbox"/> U/K</td><td></td></tr> </table>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Opiates	<input type="checkbox"/> Prescription drugs	<input type="checkbox"/> Over-the-counter	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K		<p>12. Parents ever victim of child maltreatment?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr><td><input type="checkbox"/> Physical</td><td><input type="checkbox"/> Neglect</td></tr> <tr><td><input type="checkbox"/> Sexual</td><td><input type="checkbox"/> Emotional/psychological</td></tr> <tr><td><input type="checkbox"/> U/K</td><td></td></tr> </table> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care or adopted</p>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/> Physical	<input type="checkbox"/> Neglect	<input type="checkbox"/> Sexual	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> U/K		<p>13. Parents ever perpetrator of maltreatment?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr><td><input type="checkbox"/> Physical</td><td><input type="checkbox"/> Neglect</td></tr> <tr><td><input type="checkbox"/> Sexual</td><td><input type="checkbox"/> Emotional/psychological</td></tr> <tr><td><input type="checkbox"/> U/K</td><td></td></tr> </table> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</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>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/> Physical	<input type="checkbox"/> Neglect	<input type="checkbox"/> Sexual	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> U/K		<p>14. Parents have disability or chronic illness?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Physical/orthopedic, specify:</td> <td><input type="checkbox"/> Mental health/substance abuse, specify:</td> </tr> <tr> <td><input type="checkbox"/> Cognitive/intellectual, specify:</td> <td><input type="checkbox"/> Sensory, specify:</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td></td> </tr> </table> <p>If mental health/substance abuse, was parent receiving MH services?</p> <table style="width:100%;"> <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>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<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		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K	
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15. Parents have prior child deaths?

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

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

<u>Female</u> <input type="checkbox"/> Child abuse # _____	<u>Female</u> <input type="checkbox"/> Suicide # _____	<u>Female</u> <input type="checkbox"/> Other # _____
<u>Male</u> <input type="checkbox"/> Child neglect # _____	<u>Male</u> <input type="checkbox"/> SIDS # _____	<u>Male</u> <input type="checkbox"/> Other, specify:
<input type="checkbox"/> Accident # _____	<input type="checkbox"/> Undetermined cause # _____	<input type="checkbox"/> U/K

<p>16. Parents have history of intimate partner violence?</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="checkbox"/> Yes, as victim</td> <td><u>Male</u> <input type="checkbox"/> Yes, as perpetrator</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>Female</u> <input type="checkbox"/> Yes, as victim	<u>Male</u> <input type="checkbox"/> Yes, as perpetrator	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<p>17. Parents have delinquent/criminal history? If yes, check all that apply:</p> <table style="width:100%;"> <tr> <td><u>Female</u> <input type="radio"/> Yes</td> <td><u>Male</u> <input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%;"> <tr><td><input type="checkbox"/> Assaults</td><td><input type="checkbox"/> Robbery</td></tr> <tr><td><input type="checkbox"/> Drugs</td><td><input type="checkbox"/> Other, specify:</td></tr> <tr><td><input type="checkbox"/> U/K</td><td></td></tr> </table>	<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/> Assaults	<input type="checkbox"/> Robbery	<input type="checkbox"/> Drugs	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K	
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<input type="checkbox"/> U/K	<input type="checkbox"/> U/K																		
<u>Female</u> <input type="radio"/> Yes	<u>Male</u> <input type="radio"/> Yes																		
<input type="radio"/> No	<input type="radio"/> No																		
<input type="radio"/> U/K	<input type="radio"/> U/K																		
<input type="checkbox"/> Assaults	<input type="checkbox"/> Robbery																		
<input type="checkbox"/> Drugs	<input type="checkbox"/> Other, specify:																		
<input type="checkbox"/> U/K																			

C. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two.						2. Caregiver(s) age in years:																																																																																	
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8. Caregiver(s) education:		9. Do caregiver(s) speak and understand English?		10. Caregiver(s) first generation immigrant?		12. Caregiver(s) receive social services in the past twelve months?																																																																																	
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13. Caregiver(s) have substance abuse history?		14. Caregiver(s) ever victim of child maltreatment?		15. Caregiver(s) ever perpetrator of maltreatment?		16. Caregiver(s) have disability or chronic illness?																																																																																	
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D. SUPERVISOR INFORMATION

Answer this section only if the child ever left the hospital following birth

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> Yes, answer D2-16</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sec. E</p> <p><input type="radio"/> No, but needed, answer D3-16</p> <p><input type="radio"/> Unable to determine, try to answer D3-16</p>	<p>2. How long before incident did supervisor last see child?</p> <p>Select one:</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>3. Is supervisor listed in a previous section?</p> <p><input type="radio"/> Yes, biological mother, go to D15</p> <p><input type="radio"/> Yes, biological father, go to D15</p> <p><input type="radio"/> Yes, caregiver one, go to D15</p> <p><input type="radio"/> Yes, caregiver two, go to D15</p> <p><input type="radio"/> No</p>	<p>4. Primary person responsible for supervision at the time of incident? Select only one:</p> <p><input type="radio"/> Adoptive parent <input type="radio"/> Grandparent <input type="radio"/> Institutional staff, go to D15</p> <p><input type="radio"/> Stepparent <input type="radio"/> Sibling <input type="radio"/> Babysitter</p> <p><input type="radio"/> Foster parent <input type="radio"/> Other relative <input type="radio"/> Licensed child care worker</p> <p><input type="radio"/> Mother's partner <input type="radio"/> Friend <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Father's partner <input type="radio"/> Acquaintance <input type="radio"/> U/K</p> <p><input type="radio"/> Hospital staff, go to D15</p>		
<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</p>	<p>7. Supervisor speaks and understands English?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
<p>9. Supervisor has substance abuse history?</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>10. Supervisor has history of child maltreatment?</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"/> 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>11. Supervisor has disability or chronic illness?</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/orthopedic, specify:</p> <p><input type="checkbox"/> Mental health/substance abuse, specify:</p> <p><input type="checkbox"/> Cognitive/intellectual, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental health/substance abuse, 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>12. Supervisor has prior child deaths?</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"/> Undetermined cause # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>

<p>13. Supervisor has history of intimate partner violence?</p> <p><input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> U/K</p>	<p>14. Supervisor has delinquent or criminal history?</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"/> Assault</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>15. At the time of the incident, was the supervisor asleep?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, select the most appropriate description of the supervisor's sleeping period at incident:</p> <p><input type="radio"/> Night time sleep</p> <p><input type="radio"/> Day time nap, describe:</p> <p><input type="radio"/> Day time sleep (for example, supervisor is night shift worker), describe:</p> <p><input type="radio"/> Other, describe:</p>	<p>16. At time of incident was supervisor impaired?</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"/> Drug impaired, specify:</p> <p><input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> Absent</p> <p><input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> Other, specify:</p>
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E. INCIDENT INFORMATION

Answer this section only if the child ever left the hospital following birth

<p>1. Was the date of the incident the same as the date of death?</p> <p><input type="radio"/> Yes, same as date of death</p> <p><input type="radio"/> No, different than date of death. Enter date of incident: _____ / _____ / _____</p> <p><input type="radio"/> U/K</p>	<p>2. Approximate time of day that incident occurred?</p> <p><input type="radio"/> AM</p> <p>Hour, specify 1-12 _____ <input type="radio"/> PM</p> <p><input type="radio"/> U/K</p>																														
<p>3. Place of incident, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Child's home</td> <td><input type="checkbox"/> Licensed child care center</td> <td><input type="checkbox"/> Indian reservation/ trust lands</td> <td><input type="checkbox"/> Driveway</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Relative's home</td> <td><input type="checkbox"/> Licensed child care home</td> <td><input type="checkbox"/> Military installation</td> <td><input type="checkbox"/> Other parking area</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Friend's home</td> <td><input type="checkbox"/> Unlicensed child care home</td> <td><input type="checkbox"/> Jail/detention facility</td> <td><input type="checkbox"/> State or county park</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Licensed foster care home</td> <td><input type="checkbox"/> Farm/ranch</td> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> Sports area</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Relative foster care home</td> <td><input type="checkbox"/> School</td> <td><input type="checkbox"/> Roadway</td> <td><input type="checkbox"/> Other recreation area</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Licensed group home</td> <td><input type="checkbox"/> Place of work</td> <td></td> <td><input type="checkbox"/> Hospital</td> <td></td> </tr> </table>	<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Indian reservation/ trust lands	<input type="checkbox"/> Driveway	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Military installation	<input type="checkbox"/> Other parking area		<input type="checkbox"/> Friend's home	<input type="checkbox"/> Unlicensed child care home	<input type="checkbox"/> Jail/detention facility	<input type="checkbox"/> State or county park		<input type="checkbox"/> Licensed foster care home	<input type="checkbox"/> Farm/ranch	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Sports area	<input type="checkbox"/> U/K	<input type="checkbox"/> Relative foster care home	<input type="checkbox"/> School	<input type="checkbox"/> Roadway	<input type="checkbox"/> Other recreation area		<input type="checkbox"/> Licensed group home	<input type="checkbox"/> Place of work		<input type="checkbox"/> Hospital		<p>4. Type of area:</p> <p><input type="radio"/> Urban</p> <p><input type="radio"/> Suburban</p> <p><input type="radio"/> Rural</p> <p><input type="radio"/> Frontier</p> <p><input type="radio"/> U/K</p>
<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Indian reservation/ trust lands	<input type="checkbox"/> Driveway	<input type="checkbox"/> Other, specify:																											
<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Military installation	<input type="checkbox"/> Other parking area																												
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<input type="checkbox"/> Licensed group home	<input type="checkbox"/> Place of work		<input type="checkbox"/> Hospital																												

5. Incident state:	7. Did the death occur due to a natural disaster or mass fatality? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:	8. 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:
6. Incident county:		
9. Was 911 or local emergency called? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
10. 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? _____
11. At time of incident leading to death, had child used drugs or alcohol? If yes, check all that apply: <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Alcohol <input type="checkbox"/> Opiate <input type="checkbox"/> U/K <input type="checkbox"/> Cocaine <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Marijuana <input type="checkbox"/> Over-the-counter drugs <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify:		12. 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: 13. Total number of deaths at incident event, including child: _____ Children, ages 0-18 <input type="radio"/> U/K _____ Adults

F. INVESTIGATION INFORMATION

1. Was a death investigation conducted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Medical examiner <input type="checkbox"/> Law enforcement <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Coroner <input type="checkbox"/> Fire investigator <input type="checkbox"/> Other, specify: <input type="checkbox"/> ME investigator <input type="checkbox"/> EMS <input type="checkbox"/> U/K <input type="checkbox"/> Coroner investigator <input type="checkbox"/> U/K	2. Death referred to: <input type="radio"/> Medical examiner <input type="radio"/> Coroner <input type="radio"/> Not referred <input type="radio"/> U/K	3. 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"/> Other physician <input type="radio"/> U/K
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4. Autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, conducted by: <input type="radio"/> Forensic pathologist <input type="radio"/> Unknown type pathologist <input type="radio"/> Pediatric pathologist <input type="radio"/> Other physician <input type="radio"/> General pathologist <input type="radio"/> Other, specify: <input type="radio"/> U/K	If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify specialist: _____ If no, why not (e.g. parent or caregiver objected)?
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5. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F9. <u>Yes</u> <u>No</u> <u>U/K</u> Imaging: <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - single <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - multiple views <input type="radio"/> <input type="radio"/> <input type="radio"/> X-ray - complete skeletal series <input type="radio"/> <input type="radio"/> <input type="radio"/> Other imaging, specify (includes MRI, CT scan, photos of the brain, etc): External Exam: <input type="radio"/> <input type="radio"/> <input type="radio"/> Exam of general appearance <input type="radio"/> <input type="radio"/> <input type="radio"/> Head circumference Other Autopsy Procedures: <input type="radio"/> <input type="radio"/> <input type="radio"/> Was a gross examination of organs done? <input type="radio"/> <input type="radio"/> <input type="radio"/> Were weights of any organs taken?	6. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F9. <u>Yes</u> <u>No</u> <u>U/K</u> <input type="radio"/> <input type="radio"/> <input type="radio"/> Cultures for infectious disease <input type="radio"/> <input type="radio"/> <input type="radio"/> Microscopic/histologic exam <input type="radio"/> <input type="radio"/> <input type="radio"/> Postmortem metabolic screen <input type="radio"/> <input type="radio"/> <input type="radio"/> Vitreous testing <input type="radio"/> <input type="radio"/> <input type="radio"/> Genetic testing
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7. Was any toxicology testing performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what were the results? <input type="checkbox"/> Negative <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Too high Rx drug, specify: <input type="checkbox"/> Other, specify: Check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Opiates <input type="checkbox"/> Too high OTC drug, specify: <input type="checkbox"/> U/K	
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8. Was the child's medical history reviewed as part of the autopsy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, did this include: Review of the newborn metabolic screen results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Not performed Review of neonatal CCHD screen results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Not performed	9. Describe any abnormalities or other significant findings noted in the autopsy:
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10. What additional information would the team like to have known about the autopsy?	12. Was a death scene investigation conducted at the place of the incident? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, which of the following death scene investigation components were completed? <u>Yes</u> <u>No</u> <u>U/K</u> <input type="radio"/> <input type="radio"/> <input type="radio"/> CDC's SUIDI Reporting Form or jurisdictional equivalent <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> <input type="radio"/> <input type="radio"/> Narrative description of circumstances <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> <input type="radio"/> <input type="radio"/> Scene photos <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> <input type="radio"/> <input type="radio"/> Scene recreation with doll <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> <input type="radio"/> <input type="radio"/> Scene recreation without doll <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> <input type="radio"/> <input type="radio"/> Witness interviews <input type="radio"/> Yes <input type="radio"/> No
11. Was there agreement between the cause of death listed on the pathology report and on the death certificate? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, describe the differences:	

13. What additional information would the team like to have known about the death scene investigation?
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14. Was a CPS record check conducted as a result of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
15. Did any investigation find evidence of prior abuse? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, from what source? Check all that apply: <input type="checkbox"/> X-rays <input type="checkbox"/> U/K <input type="checkbox"/> Autopsy <input type="checkbox"/> CPS review <input type="checkbox"/> Law enforcement	16. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <table style="width:100%;"> <tr> <td style="width:33%;"> 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 </td> <td style="width:67%;"> If yes, what services or actions resulted? Check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Court-ordered out of home placement <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Children removed <input type="checkbox"/> Court-ordered services provided <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> Voluntary out of home placement <input type="checkbox"/> U/K </td> </tr> </table>	If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated	If yes, what services or actions resulted? Check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Court-ordered out of home placement <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Children removed <input type="checkbox"/> Court-ordered services provided <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> Voluntary out of home placement <input type="checkbox"/> U/K	17. If death occurred in licensed setting (see E3), indicate action taken: <input type="radio"/> No action <input type="radio"/> License suspended <input type="radio"/> License revoked <input type="radio"/> Investigation ongoing <input type="radio"/> Other, specify: <input type="radio"/> U/K
If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated	If yes, what services or actions resulted? Check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Court-ordered out of home placement <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Children removed <input type="checkbox"/> Court-ordered services provided <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> Voluntary out of home placement <input type="checkbox"/> U/K			

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: _____ <input type="checkbox"/> U/K
2. Enter the following information exactly as written on the death certificate: <input type="checkbox"/> U/K Immediate cause (final disease or condition resulting in death): a. Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death: b. c. d.
3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate: <input type="checkbox"/> U/K
4. If injury, describe how injury occurred exactly as written on the death certificate: <input type="checkbox"/> U/K

5. Official manner of death from the death certificate: <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K	6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause. <table style="width:100%;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u> <input type="radio"/> Motor vehicle and other transport, go to H1 <input type="radio"/> Fire, burn, or electrocution, go to H2 <input type="radio"/> Drowning, go to H3 <input type="radio"/> Unintentional asphyxia, go to H4 <input type="radio"/> Assault, weapon or person's body part, go to H5 <input type="radio"/> Fall or crush, go to H6 <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 <input type="radio"/> Undetermined injury, go to I2 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I2 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma/respiratory, specify and go to H8 <input type="radio"/> Cancer, specify and go to H8 <input type="radio"/> Cardiovascular, specify and go to H8 <input type="radio"/> Congenital anomaly, specify and go to H8 <input type="radio"/> Diabetes, go to H8 <input type="radio"/> HIV/AIDS, go to H8 <input type="radio"/> Influenza, go to H8 <input type="radio"/> Low birth weight, go to H8 <input type="radio"/> Malnutrition/dehydration, go to H8 <input type="radio"/> Neurological/seizure disorder, go to H8 <input type="radio"/> Pneumonia, specify and go to H8 <input type="radio"/> Prematurity, go to H8 <input type="radio"/> SIDS, go to H8 <input type="radio"/> Other infection, specify and go to H8 <input type="radio"/> Other perinatal condition, specify and go to H8 <input type="radio"/> Other medical condition, specify and go to H8 <input type="radio"/> Undetermined medical cause, go to H8 <input type="radio"/> U/K, go to H8 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>Undetermined if injury or medical cause, go to I2</u> <input type="radio"/> <u>U/K go to I2</u> </td> </tr> </table>	<input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u> <input type="radio"/> Motor vehicle and other transport, go to H1 <input type="radio"/> Fire, burn, or electrocution, go to H2 <input type="radio"/> Drowning, go to H3 <input type="radio"/> Unintentional asphyxia, go to H4 <input type="radio"/> Assault, weapon or person's body part, go to H5 <input type="radio"/> Fall or crush, go to H6 <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 <input type="radio"/> Undetermined injury, go to I2 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I2	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma/respiratory, specify and go to H8 <input type="radio"/> Cancer, specify and go to H8 <input type="radio"/> Cardiovascular, specify and go to H8 <input type="radio"/> Congenital anomaly, specify and go to H8 <input type="radio"/> Diabetes, go to H8 <input type="radio"/> HIV/AIDS, go to H8 <input type="radio"/> Influenza, go to H8 <input type="radio"/> Low birth weight, go to H8 <input type="radio"/> Malnutrition/dehydration, go to H8 <input type="radio"/> Neurological/seizure disorder, go to H8 <input type="radio"/> Pneumonia, specify and go to H8 <input type="radio"/> Prematurity, go to H8 <input type="radio"/> SIDS, go to H8 <input type="radio"/> Other infection, specify and go to H8 <input type="radio"/> Other perinatal condition, specify and go to H8 <input type="radio"/> Other medical condition, specify and go to H8 <input type="radio"/> Undetermined medical cause, go to H8 <input type="radio"/> U/K, go to H8	<input type="radio"/> <u>Undetermined if injury or medical cause, go to I2</u> <input type="radio"/> <u>U/K go to I2</u>
<input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u> <input type="radio"/> Motor vehicle and other transport, go to H1 <input type="radio"/> Fire, burn, or electrocution, go to H2 <input type="radio"/> Drowning, go to H3 <input type="radio"/> Unintentional asphyxia, go to H4 <input type="radio"/> Assault, weapon or person's body part, go to H5 <input type="radio"/> Fall or crush, go to H6 <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 <input type="radio"/> Undetermined injury, go to I2 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I2	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma/respiratory, specify and go to H8 <input type="radio"/> Cancer, specify and go to H8 <input type="radio"/> Cardiovascular, specify and go to H8 <input type="radio"/> Congenital anomaly, specify and go to H8 <input type="radio"/> Diabetes, go to H8 <input type="radio"/> HIV/AIDS, go to H8 <input type="radio"/> Influenza, go to H8 <input type="radio"/> Low birth weight, go to H8 <input type="radio"/> Malnutrition/dehydration, go to H8 <input type="radio"/> Neurological/seizure disorder, go to H8 <input type="radio"/> Pneumonia, specify and go to H8 <input type="radio"/> Prematurity, go to H8 <input type="radio"/> SIDS, go to H8 <input type="radio"/> Other infection, specify and go to H8 <input type="radio"/> Other perinatal condition, specify and go to H8 <input type="radio"/> Other medical condition, specify and go to H8 <input type="radio"/> Undetermined medical cause, go to H8 <input type="radio"/> U/K, go to H8	<input type="radio"/> <u>Undetermined if injury or medical cause, go to I2</u> <input type="radio"/> <u>U/K go to I2</u>		

H. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE THE ONE SECTION THAT IS SAME AS THE CAUSE SELECTED ABOVE

H1. MOTOR VEHICLE AND OTHER TRANSPORT

<p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <table border="0" style="width:100%;"> <tr> <td style="width:15%;"><u>Child's</u></td> <td style="width:15%;"><u>Other primary vehicle</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>None</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Car</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Van</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Sport utility vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Truck</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Semi/tractor trailer</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>RV</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>School bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Motorcycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Tractor</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other farm vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>All terrain vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Snowmobile</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Bicycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Train</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Subway</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Trolley</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>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 border="0" style="width:100%;"> <tr> <td style="width:33%;"><input type="radio"/> Front seat</td> <td style="width:33%;"><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 border="0" 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 border="0" 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 border="0" 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:

<u>Child as driver</u>	<u>Child's driver</u>	<u>Driver of other primary vehicle</u>	<u>Child as driver</u>	<u>Child's driver</u>	<u>Driver of other primary vehicle</u>
	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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license
	<input type="radio"/>	<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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a suspended license
	<input type="radio"/>	<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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:
	<input type="radio"/>	<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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nighttime driving curfew
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Responsible for causing incident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Passenger restrictions
<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/> Has no license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other violations, specify:
<input type="checkbox"/>	<input type="checkbox"/>	<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:

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

	<u>Not Needed</u>	<u>Needed, none present</u>	<u>Present, used correctly</u>	<u>Present, used incorrectly</u>	<u>Present, not used</u>	<u>U/K</u>
Select one option per row:						
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

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source: <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning <input type="radio"/> Other explosives <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Oxygen tank <input type="radio"/> Appliance in water <input type="radio"/> Utility lighter <input type="radio"/> Furnace <input type="radio"/> Hot cooking water <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"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> Other hot liquid, specify: <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring <input type="radio"/> Fireworks <input type="radio"/> U/K				b. Type of incident: <input type="radio"/> Fire, go to c <input type="radio"/> Scald, go to r <input type="radio"/> Other burn, go to t <input type="radio"/> Electrocution, go to s <input type="radio"/> Other, specify and go to t <input type="radio"/> U/K, go to t		c. For fire, child died from: <input type="radio"/> Burns <input type="radio"/> Smoke inhalation <input type="radio"/> Other, specify: <input type="radio"/> U/K																		
d. Material first ignited: <input type="radio"/> Upholstery <input type="radio"/> Mattress <input type="radio"/> Christmas tree <input type="radio"/> Clothing <input type="radio"/> Curtain <input type="radio"/> Other, specify: <input type="radio"/> U/K		e. Type of building on fire: <input type="radio"/> N/A <input type="radio"/> Single home <input type="radio"/> Duplex <input type="radio"/> Apartment <input type="radio"/> Trailer/mobile home <input type="radio"/> Other, specify: <input type="radio"/> U/K		f. Building's primary construction material: <input type="radio"/> Wood <input type="radio"/> Steel <input type="radio"/> Brick/stone <input type="radio"/> Aluminum <input type="radio"/> Other, specify: <input type="radio"/> U/K		g. Fire started by a person? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, person's age _____ Does person have a history of setting fires? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		h. Did anyone attempt to put out fire? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K i. Did escape or rescue efforts worsen fire? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K j. Did any factors delay fire department arrival? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:																
k. Were barriers preventing safe exit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Locked door <input type="checkbox"/> Window grate <input type="checkbox"/> Locked window <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		l. Was building a rental property? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K o. Was sprinkler system present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was it working? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		m. Were building/rental codes violated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe in narrative.		n. Were proper working fire extinguishers present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		p. Were smoke detectors present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 2px;"> If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K </td> <td style="width: 33%; border-right: 1px solid black; padding: 2px;"> If yes, functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K </td> <td style="width: 33%; padding: 2px;"> If not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other, specify: _____ </td> </tr> </table> If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <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 not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	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"/>
If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <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 not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	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"/>										
Missing batteries	Other	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"/>																						
q. Suspected arson? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		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		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		t. Other, describe in detail:																		

H3. DROWNING

a. Where was child last seen before drowning? Check all that apply: <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		b. What was child last seen doing before drowning? <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		c. Was child forcibly submerged? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		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	
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		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		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		h. For boating, was the child piloting boat? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
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		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		k. For pool, ownership is: <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K		l. Length of time owners had pool/hot tub/spa: <input type="radio"/> N/A <input type="radio"/> >1yr <input type="radio"/> <6 months <input type="radio"/> U/K <input type="radio"/> 6m-1 yr	

<p>m. Flotation device used?</p> <input type="radio"/> N/A If yes, check all that apply: <input type="radio"/> Yes <input type="checkbox"/> Coast Guard approved <input type="checkbox"/> Not Coast Guard approved <input type="checkbox"/> U/K <input type="radio"/> No <input type="checkbox"/> Jacket <input type="checkbox"/> Cushion <input type="checkbox"/> Lifesaving ring <input type="checkbox"/> Swim rings <input type="radio"/> U/K If jacket: Correct size? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Inner tube Worn correctly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Air mattress <input type="checkbox"/> Other, specify: _____		<p>n. What barriers/layers of protection existed to prevent access to water?</p> 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>o. Fence:</p> 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. Gate, check all that apply:</p> <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>q. Door, check all that apply:</p> <input type="checkbox"/> Patio door <input type="checkbox"/> Opens to water <input type="checkbox"/> Screen door <input type="checkbox"/> Barrier between door and water <input type="checkbox"/> Steel door <input type="checkbox"/> Self-closing <input type="checkbox"/> U/K <input type="checkbox"/> Has lock	<p>r. Alarm, check all that apply:</p> <input type="checkbox"/> Door <input type="checkbox"/> Window <input type="checkbox"/> Pool <input type="checkbox"/> Laser <input type="checkbox"/> U/K	<p>s. Type of cover:</p> <input type="radio"/> Hard <input type="radio"/> Soft <input type="radio"/> U/K	
<p>t. Local ordinance(s) regulating access to water?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, rules violated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>u. How were layers of protection breached? Check all that apply:</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>v. Child able to swim?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>w. For bathtub, child in a bathing aid?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify type: _____	<p>x. Warning sign or label posted?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>y. Lifeguard present?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		
<p>z. Rescue attempt made?</p> <input type="radio"/> N/A If yes, who? Check all that apply: <input type="radio"/> Yes <input type="checkbox"/> Parent <input type="checkbox"/> Bystander <input type="radio"/> No <input type="checkbox"/> Other child <input type="checkbox"/> Other, specify: <input type="radio"/> U/K <input type="checkbox"/> Lifeguard <input type="checkbox"/> U/K		<p>aa. Did rescuer(s) also drown?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, number of rescuers that drowned: _____		<p>bb. Appropriate rescue equipment present?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	
H4. UNINTENTIONAL ASPHYXIA					
<p>a. Type of event:</p> <input type="radio"/> Suffocation, go to b <input type="radio"/> Strangulation, go to c <input type="radio"/> Choking, go to d <input type="radio"/> Other, specify and go to e <input type="radio"/> U/K, go to e		<p>b. If suffocation/asphyxia, action causing event:</p> <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 specify: <input type="radio"/> Dirt/sand <input type="radio"/> Automobile <input type="radio"/> Asphyxia by gas, go to H7g <input type="radio"/> Other, specify: _____ <input type="radio"/> Trunk <input type="radio"/> Other, specify: <input type="radio"/> U/K <input type="radio"/> Other, specify: _____ <input type="radio"/> U/K <input type="radio"/> U/K <input type="radio"/> Other, specify: _____ <input type="radio"/> U/K			
<p>c. If strangulation, object causing event:</p> <input type="radio"/> Clothing <input type="radio"/> Leash <input type="radio"/> Blind cord <input type="radio"/> Electrical cord <input type="radio"/> Car seat <input type="radio"/> Person, go to H5q <input type="radio"/> Stroller <input type="radio"/> Automobile power window <input type="radio"/> High chair or sunroof <input type="radio"/> Belt <input type="radio"/> Other, specify: <input type="radio"/> Rope/string <input type="radio"/> U/K		<p>d. If choking, object causing choking:</p> <input type="radio"/> Food, specify: <input type="radio"/> Toy, specify: <input type="radio"/> Balloon <input type="radio"/> Other, specify: <input type="radio"/> U/K		<p>e. Was asphyxia an autoerotic event?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<p>f. Was child participating in 'choking game' or 'pass out game'?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>g. History of seizures?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # _____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
<p>h. History of apnea?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # _____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>i. Was Heimlich Maneuver attempted?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

H5. ASSAULT, WEAPON OR PERSON'S BODY PART

<p>a. Type of weapon:</p> <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m	<p>b. For firearms, type:</p> <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Firearm licensed?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Firearm safety features, check all that apply:</p> <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> <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K			<p>f. Firearm stored with ammunition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<p>g. Firearm stored loaded?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

<p>h. Owner of fatal firearm:</p> <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"/> Mother's partner <input type="radio"/> Other, specify: <input type="radio"/> Father's partner <input type="radio"/> Classmate <input type="radio"/> U/K	<p>i. Sex of fatal firearm owner:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	<p>j. Type of sharp object:</p> <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>k. Type of blunt object:</p> <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K
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<p>l. What did person's body part do? Check all that apply:</p> <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle/choke <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>m. Did person using weapon have history of weapon-related offenses?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</p> <input type="radio"/> Yes, describe circumstances: <input type="radio"/> No <input type="radio"/> U/K	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left;"><u>Fatal and/or Other weapon</u></th> <th style="text-align: left;"><u>Fatal and/or Other weapon</u></th> </tr> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	<u>Fatal and/or Other weapon</u>	<u>Fatal and/or Other weapon</u>	<input type="checkbox"/> Self	<input type="checkbox"/> Friend	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger	<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
<u>Fatal and/or Other weapon</u>	<u>Fatal and/or Other weapon</u>																											
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<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																											
<p>Other weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																												

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

<input type="checkbox"/> Self injury	<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"/> Commission of crime	<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"/> Drug dealing/trading	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> Other, specify:
<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"/> U/K
<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon	

H6. 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> <p>_____ feet</p> <p>_____ inches</p> <input type="checkbox"/> U/K	<p>c. Child fell from:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td><input type="radio"/> U/K</td> </tr> </table>	<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
<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> <p>Check all that apply:</p> <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 <p>If yes, go to H5q</p>	<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"/> Television <input type="radio"/> Furniture <input type="radio"/> Walls <input type="radio"/> Playground equipment <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> Boulders/rocks <input type="radio"/> Dirt/sand <input type="radio"/> Person, go to H5q <input type="radio"/> Commercial equipment <input type="radio"/> Farm equipment <input type="radio"/> Other, specify: <input type="radio"/> U/K
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H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply: U/K

<u>Prescription drug</u>	<u>Over-the-counter drug</u>	<u>Illicit drugs</u>	<u>Other substances</u>
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Pain medication	<input type="checkbox"/> Pain medication (opiate)	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Pain medication (opiate)	<input type="checkbox"/> Cold medicine	<input type="checkbox"/> Pain medication (non-opiate)	<input type="checkbox"/> Carbon monoxide, go to e
<input type="checkbox"/> Pain medication (non-opiate)	<input type="checkbox"/> Other OTC, specify:	<input type="checkbox"/> Methadone	<input type="checkbox"/> Other fume/gas/vapor
<input type="checkbox"/> Methadone		<input type="checkbox"/> Cocaine	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Other Rx, specify:		<input type="checkbox"/> Heroin	
If prescription, was it child's? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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. 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>f. Was Poison Control called?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, who called:</p> <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>g. For CO poisoning, was a CO detector present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, how many? _____</p> <p>Functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
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H8. MEDICAL CONDITION

<p>a. How long did the child have the medical condition?</p> <input type="radio"/> In utero <input type="radio"/> Weeks <input type="radio"/> Since birth <input type="radio"/> Months <input type="radio"/> Hours <input type="radio"/> Years <input type="radio"/> Days <input type="radio"/> U/K	<p>b. Was death expected as a result of the medical condition?</p> <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	<p>c. Was child receiving health care for the medical condition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, within 48 hours of the death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Were the prescribed care plans appropriate for the medical condition?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K
<p>e. Was child/family compliant with the prescribed care plans?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If no, what wasn't compliant? Check all that apply.</p> <input type="checkbox"/> Appointments <input type="checkbox"/> Medications, specify: <input type="checkbox"/> Medical equipment use, specify:	<p>f. Was the medical condition associated with an outbreak?</p> <input type="checkbox"/> Therapies, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>g. Was environmental tobacco exposure a contributing factor in death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	

<p>h. Were there access or compliance issues related to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Lack of transportation <input type="checkbox"/> No phone <input type="checkbox"/> Cultural differences <input type="checkbox"/> Language barriers <input type="checkbox"/> Couldn't get provider to take as patient <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Couldn't get an earlier appointment <input type="checkbox"/> Lack of child care <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Services not available <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Caregiver unwilling to provide care <input type="checkbox"/> Didn't know where to go <input type="checkbox"/> Mother didn't think she was pregnant <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>i. Was death caused by a medical misadventure?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

I2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:

WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?

Yes, go to I2a No, go to I2s U/K, go to I2a

a. Incident sleep place:

<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	If adult bed, what type?	If futon,
If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play		
<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Full	<input type="radio"/> Couch position
<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> Queen	<input type="radio"/> U/K
<input type="radio"/> Unknown crib type		<input type="radio"/> Bouncy chair	<input type="radio"/> King	If car seat, was car seat secured in seat of car?
<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair		<input type="radio"/> U/K	
<input type="radio"/> Baby box	<input type="radio"/> Floor	<input type="radio"/> U/K		

<p>b. Child put to sleep:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>c. Child found:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>e. Usual sleep position:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>f. Was there any type of crib, Pack 'n Play, bassinet, bed side sleeper or baby box in home for child?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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d. Usual sleep place:

<input type="radio"/> Crib	<input type="radio"/> Baby box	<input type="radio"/> Floor	If adult bed, what type?
If crib, type:	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	
<input type="radio"/> Not portable	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Full <input type="radio"/> Other, specify:
<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Queen <input type="radio"/> U/K
<input type="radio"/> Unknown crib type	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	
<input type="radio"/> Bassinet		<input type="radio"/> Bouncy chair	If futon,
<input type="radio"/> Bed side sleeper	<input type="radio"/> Couch	<input type="radio"/> Other, specify:	<input type="radio"/> Bed position
	<input type="radio"/> Chair	<input type="radio"/> U/K	<input type="radio"/> Couch position
			<input type="radio"/> U/K

<p>g. Child in a new or different environment than usual?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe why:	<p>h. Child last placed to sleep with a pacifier?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>i. Child wrapped or swaddled in blanket?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:
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<p>j. Child overheated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, outside temp ____ degrees F</p> <p>Check all that apply:</p> <input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing	<p>k. Child exposed to second hand smoke?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, how often:</p> <input type="radio"/> Frequently <input type="radio"/> Occasionally <input type="radio"/> U/K
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<p>l. Child's face when found:</p> <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	<p>m. Child's neck when found:</p> <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> Turned <input type="radio"/> U/K	<p>n. Child's airway (includes nose, mouth, neck and/or chest):</p> <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	<p>If fully or partially obstructed, what was obstructed?</p> <input type="checkbox"/> Nose <input type="checkbox"/> Chest compressed <input type="checkbox"/> Mouth <input type="checkbox"/> U/K <input type="checkbox"/> Neck compressed <p>If fully or partially obstructed, describe obstruction in detail:</p>
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o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	If present, describe position of object:									If present, did object obstruct airway?		
	Present?			On top	Under	Next	Tangled	U/K	Yes	No	U/K	
	Yes	No	U/K	of child	child	to child	around child					
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fitted sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

→ If adult(s) obstructed airway, describe relationship of adult to child (for example, biological mother):

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

q. Child sleeping in the same room as caregiver/supervisor at time of death?
 Yes No U/K

r. Child sleeping on same surface with person(s) or animal(s)?
 Yes No U/K

If yes, reasons stated for sleeping on same surface, check all that apply:
 To feed
 To soothe
 Usual sleep pattern
 No infant bed available
 Home/living space overcrowded
 Other, specify:
 U/K

If yes, check all that apply:
 With adult(s): # _____ # U/K
 Adult obese: Yes No U/K
 With other children: # _____ # U/K Children's ages: _____
 With animal(s): # _____ # U/K Type(s) of animal: _____

s. Is there a scene re-creation photo available for upload? Yes No If yes, upload here. Only one photo allowed.
 Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

13. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? Yes No, go to I4 U/K, go to I4

a. Describe product and circumstances:

b. Was product used properly? Yes No U/K

c. Is a recall in place? Yes No U/K

d. Did product have safety label? Yes No U/K

e. Was Consumer Product Safety Commission (CPSC) notified?
 Yes
 No, go to www.saferproducts.gov to report
 U/K

14. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? Yes No, go to I5 U/K, go to I5

a. Type of crime, check all that apply:

<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:	

I5. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS			
<p>a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?</p> <p><input type="radio"/> Yes/probable <input type="radio"/> No, go to next section <input type="radio"/> U/K, go to next section</p> <p>If yes/probable, choose primary reason:</p> <p><input type="radio"/> Child abuse, go to I5b <input type="radio"/> Child neglect, go to I5f <input type="radio"/> Poor/absent supervision, go to I5h <input type="radio"/> Exposure to hazards, go to I5g</p>	<p>b. Type of child abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to I5c <input type="checkbox"/> Chronic Battered Child Syndrome, go to I5e <input type="checkbox"/> Beating/kicking, go to I5e <input type="checkbox"/> Scalding or burning, go to I5e <input type="checkbox"/> Munchausen Syndrome by Proxy, go to I5e <input type="checkbox"/> Sexual assault, go to I5h <input type="checkbox"/> Other, specify and go to I5h <input type="checkbox"/> U/K, go to I5e</p>	<p>c. For abusive head trauma, were there retinal hemorrhages? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <hr/> <p>d. For abusive head trauma, was the child shaken? <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>e. Events(s) triggering child abuse, check all that apply:</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>
<p>f. Child neglect, check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div style="width:45%;"> <p><input type="checkbox"/> Failure to provide necessities</p> <ul style="list-style-type: none"> <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <p><input type="checkbox"/> Failure to provide supervision</p> <p><input type="checkbox"/> Emotional neglect, specify:</p> <p><input type="checkbox"/> Abandonment, specify:</p> <p><input type="checkbox"/> Failure to seek/follow treatment, specify:</p> <p>If yes, was this due to religious or cultural practices? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> </div> <div style="width:45%;"> <p><input type="checkbox"/> Exposure to hazards:</p> <p>Do not include child's own behavior.</p> <p><input type="radio"/> Hazard(s) in sleep environment (including sleep position and co-sleeping)</p> <p><input type="radio"/> Fire hazard</p> <p><input type="radio"/> Unsecured medication/poison</p> <p><input type="radio"/> Firearm hazard</p> <p><input type="radio"/> Water hazard</p> <p><input type="radio"/> Motor vehicle hazard</p> <p><input type="radio"/> Other hazard, specify:</p> </div> </div>			

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)		
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<p>1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?</p> <p><input type="radio"/> Yes/probable <input type="radio"/> No, go to Section K <input type="radio"/> U/K, go to Section K</p>	<p>2. What act(s)? Check only one per column and describe in narrative.</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child abuse</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Exposure to hazards</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child neglect</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Assault, not child abuse</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Poor/absent supervision</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other, specify: U/K</td> </tr> </tbody> </table>	<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>		<input type="radio"/>	<input type="radio"/>	Child abuse	<input type="radio"/>	<input type="radio"/>	Exposure to hazards	<input type="radio"/>	<input type="radio"/>	Child neglect	<input type="radio"/>	<input type="radio"/>	Assault, not child abuse	<input type="radio"/>	<input type="radio"/>	Poor/absent supervision	<input type="radio"/>	<input type="radio"/>	Other, specify: U/K	<p>3. Did the team have information about the person(s)?</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No, go to Section K</td> </tr> </tbody> </table>	<u>One</u>	<u>Two</u>		<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	No, go to Section K																																				
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<p>6. Person's age in years:</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td># Years</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </tbody> </table>	<u>One</u>	<u>Two</u>		_____	_____	# Years	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>7. Person's sex:</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Male</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Female</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </tbody> </table>	<u>One</u>	<u>Two</u>		<input type="radio"/>	<input type="radio"/>	Male	<input type="radio"/>	<input type="radio"/>	Female	<input type="radio"/>	<input type="radio"/>	U/K	<p>8. Person speaks and understands English?</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </tbody> </table> <p>If no, language spoken:</p>	<u>One</u>	<u>Two</u>		<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	U/K	<p>9. Person on active military duty?</p> <table style="width:100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>One</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Two</u></th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </tbody> </table> <p>If yes, specify branch:</p>	<u>One</u>	<u>Two</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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<p>10. Person(s) have history of substance abuse?</p> <p><u>One</u> <u>Two</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><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>11. Person(s) have history of child maltreatment as victim?</p> <p><u>One</u> <u>Two</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><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care or adopted</p>	<p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <p><u>One</u> <u>Two</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><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</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>13. Person(s) have disability or chronic illness?</p> <p><u>One</u> <u>Two</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><input type="checkbox"/> Physical/orthopedic, specify:</p> <p><input type="checkbox"/> Mental health/substance abuse, specify:</p> <p><input type="checkbox"/> Cognitive/intellectual, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental health/substance abuse, was person receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>
<p>14. Person(s) have prior child deaths?</p> <p><u>One</u> <u>Two</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>One</u> <u>Two</u></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"/> Undetermined cause # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>15. Person(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> U/K</p>	<p>16. Person(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</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><input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>
<p>17. At the time of the incident, was the person asleep?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, select the most appropriate description of the person's sleeping period at incident:</p> <p style="margin-left: 150px;"> <u>One</u> <u>Two</u> <input type="radio"/> Night time sleep <input type="radio"/> Day time nap, describe: <input type="radio"/> Day time sleep (for example, person is night shift worker), describe: <input type="radio"/> Other, describe: </p>			
<p>18. At time of incident was person impaired?</p> <p><u>One</u> <u>Two</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>One</u> <u>Two</u></p> <p><input type="checkbox"/> Drug impaired, specify:</p> <p><input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> Absent</p>	<p><u>One</u> <u>Two</u></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> Other, specify:</p>	<p>19. Person(s) have, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> Prior convictions</p>	<p>20. Legal outcomes in this death, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> Confession</p> <p><input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> U/K</p>

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

1. Were new or revised services recommended or implemented as a result of the death? Yes No U/K

If yes, select one option per row:	Referred for service	Review led to	Referral needed,		
	<u>before review</u>	<u>referral</u>	<u>not available</u>	<u>N/A</u>	<u>U/K</u>
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Debriefing for professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genetic counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home visiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

L. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

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

1. Were new or revised agency services, policies or practices recommended or implemented as a result of the review?
 Yes No U/K

If yes, select all that apply and describe:

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

3. What recommendations and/or initiatives resulted from the review? Check all that apply:

No recommendations and/or initiatives made, go to L7

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

2. Describe the risk factors in the death that the team feels need to be addressed:

4. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future:

5. Briefly describe recommendations and/or initiatives that will be or have been implemented as a result of the death:

6. Who was given the recommendation(s) and or/initiative(s) to implement? Check all that apply:

- N/A, no strategies
- No one
- Community Action Team
- Health department
- Social services
- Mental health
- Schools
- Hospital
- Other health care providers
- Law enforcement
- Medical examiner
- Coroner
- Elected official
- Advocacy organization
- Local community group
- New coalition/task force
- Youth group
- Other, specify:
- U/K

7. Could the death have been prevented? Yes, probably No, probably not Team could not determine

M. THE REVIEW MEETING PROCESS

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

4. Agencies and individuals at review meeting, check all that apply:
- Medical examiner/coroner
 - Law enforcement
 - Prosecutor/district attorney
 - Public health
 - HMO/managed care
 - CPS
 - Other social services
 - Physician
 - Nurse
 - Hospital
 - Other health care
 - Fire
 - EMS
 - Faith based organization
 - Education
 - Mental health
 - Substance abuse
 - Home visiting
 - Healthy Start
 - Court
 - Child advocate
 - Military
 - Domestic violence
 - Others, list:

5. Were the following data sources available at the review meeting?

Check all that apply:

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

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

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

7. Review meeting outcomes, check all that apply:

<input type="checkbox"/> Review led to additional investigation	<input type="checkbox"/> Review led to the delivery of services
<input type="checkbox"/> Team disagreed with official manner of death. What did team believe manner should be?	<input type="checkbox"/> Review led to changes in agency policies or practices
<input type="checkbox"/> Team disagreed with official cause of death. What did team believe cause should be?	<input type="checkbox"/> Review led to prevention initiatives being implemented
<input type="checkbox"/> Because of the review, the official cause or manner of death was changed	<input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National

O. NARRATIVE

O1. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information. DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, dates, addresses, and specific service providers. Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death? The Narrative is included in de-identified downloads, and per MPH/NCFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.

O2. FIMR ISSUES SUMMARY (Ps/Cs)

P = Present / C = Contributing

1. Pre-/Inter-/Post-conception Care

- Y N U Preconception care
- Y N U Postpartum visit kept
- Y N U Pregnancy planning/BC education
 - Before During After
- Y N U Dental/oral care
 - Before During After
- Y N U Chronic disease control education
 - Before During After
- Y N U Weight mgmt/dietician
 - Before During After
- Y N U Bereavement referral

2. Medical: Mother

- P C Early teen (17 and under) pregnancy
- P C Late teen (18 & 19) pregnancy
- P C Pregnancy >35 yrs
- P C Cord problem
- P C Placental abruption
- P C Placenta Previa
- P C Chorioamnionitis
- P C Pre-existing diabetes
- P C Gestational diabetes
- P C Incompetent cervix
- P C Infection: BV
- P C STI - _____
- P C Other source of infection: _____
- P C Multiple gestation #
- P C Mother's weight BMI:
- P C Insufficient/excess weight gain
- P C Poor nutrition
- P C Pre-existing hypertension
- P C Preeclampsia
- P C Eclampsia
- P C Preterm labor
- P C Pregnancy <18 m apart
- P C PROM
- P C PPRM
- P C Prolonged Rupture of Membrane
- P C Pre-existing dental/oral issues
- P C Oligo-/Polyhydramnios
- P C Previous SABs or miscarriages
 - # /Therap ab # /Vol ab #
- P C Previous fetal loss #
- P C Previous infant loss # _____
- P C Previous LBW delivery
- P C Previous preterm delivery
- P C Previous C-Section: #
- P C Previous ectopic pregnancy
- P C First pregnancy <18 yrs old
- P C >4 Live births
- P C Assist reprod tech:
- P C Other, specify:

3. Family Planning

- P C Intended pregnancy
- P C Unintended pregnancy
- P C Unwanted pregnancy
- P C No birth control

3. Family Planning (continued)

- P C Failed contraceptive
 - P C Lack of knowledge: methods
 - P C Lack of resources
 - P C Other, specify:
- 4. Substance Use**
- P C Positive drug test
 - P C No drug test
 - P C Tobacco use: hx, not current
 - P C Tobacco use: current
 - P C Alcohol use: hx, not current
 - P C Alcohol use: current
 - P C Illicit drug use:hx, not current
 - P C Illicit drugs: current: type: _____
 - P C Use of un-pres meds: type: _____
 - P C OTC/Rx meds: type: _____
 - P C Other, specify:

5. Prenatal Care/Delivery

- P C Standard of care not met
- P C Inadequate assessment
- P C No prenatal care
- P C Late entry to prenatal care
- P C Lack of referrals
- P C Missed appointments
- P C Multiple providers/sites
- P C Lack of dental assessment
- P C Lack of dental care
- P C Inappropriate use of ER
- P C Other, specify:

6. Medical: Fetal/Infant

- P C Non-viable fetus
- P C LBW (<2500 grams)
- P C VLBW (<1500 grams)
- P C ELBW (<750 grams)
- P C Intrauterine Growth Restriction
- P C Congenital anomaly
- P C Prematurity
- P C Infection/sepsis
- P C Failure to thrive
- P C Birth injury
- P C Feeding problem
- P C Respiratory Distress Syndrome
- P C Developmental delay
- P C Inappropriate level of care
- P C Positive drug test
- P C Other, specify:

7. Pediatric Care

- P C Standard of care not met
- P C Inadequate assessment
- P C No pediatric care
- P C Lack of referrals
- P C Missed aptmnt/immunizations
- P C Multiple providers/sites
- P C Inappropriate use of ER
- P C Other, specify:

8. Environment

- P C Unsafe neighborhood
- P C Substandard housing
- P C Overcrowding
- P C Second-hand smoke
- P C Little/no breastfeeding
- P C Improper formula prep/feeding
- P C Improper/no car seat use
- P C Unsafe sleep location
- P C Infant overheating
- P C Not back sleep position
- P C Apnea monitor, misuse
- P C Lack of adult supervision
- P C Other, specify:

9. Injuries

- P C Suffocation/strangulation
- P C Abusive head trauma
- P C General trauma
- P C Other, specify:

10. Social Support

- P C Lack of family support
- P C Lack of neighbors/ community support
- P C Lack of partner/FOB support
- P C Single parent
- P C Living alone
- P C <12th grade education
- P C Special education
- P C Physical/cognitive disability
- P C Other, specify:

11. Partner/Father of Baby/Caregiver

- P C Employment Yes No
- P C Hx of mental illness
- P C Substance or tobacco use/abuse: hx specify:
- P C Substance or tobacco use/abuse: current specify:
- P C Other, specify:

12. Family Transition

- P C Frequent/recent moves
- P C Living in shelter/homeless
- P C Concern re: citizenship
- P C Divorce/separation
- P C Multiple partners
- P C Mom: prison/parole/probation
- P C FOB: prison/parole/probation
- P C Major illness/death in family
- P C Other, specify:

13. Mental Health/Stress

- P C Hx of mental illness (mom)
- P C Depression/mental illness during pregnancy
- P C Depression/mental illness in postpartum period
- P C Multiple stresses
- P C Social chaos
- P C Employment Yes No

13. Mental Health/Stress (continued)

- P C Concern about enough money
- P C Work/employment problems
- P C Child(ren) with special needs
- P C Problems with family/relatives
- P C Lack of grief support
- P C Other, specify:

14. Family Violence/Neglect

- P C History of abuse (mom), specify:
- P C Current abuse (mom), specify:
- P C History of abuse (FOB), specify:
- P C Current abuse (FOB), specify:
- P C Hx child abuse: this infant
- P C Hx child abuse: other child
- P C Current child abuse: this infant
- P C Current child abuse: other child
- P C Hx child neglect: this infant
- P C Hx child neglect: other child
- P C Current child neglect: this infant
- P C Current child neglect: other child
- P C CPS referrals
- P C Police reports
- P C Other, specify:

15. Culture

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

16. Payment for Care

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

17. Services Provided

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

18. Transportation

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

19. Documentation

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

20. Other

- P C Other, specify:

P. FORM COMPLETED BY:

Person:	Email:		
Title:	Date completed:		
Agency:	Data entry completed for this case? <input type="checkbox"/>		
Phone:	<table border="1"><tr><td>For State Program Use Only:</td></tr><tr><td>Data quality assurance completed by state? <input type="checkbox"/></td></tr></table>	For State Program Use Only:	Data quality assurance completed by state? <input type="checkbox"/>
For State Program Use Only:			
Data quality assurance completed by state? <input type="checkbox"/>			

ADDITIONAL SPACE FOR NOTES:



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