

CDR Report Form

National Fatality Review

Case Reporting System

Version 5.1



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

1-800-656-2434

info@ncfrp.org

www.ncfrp.org

SAVING LIVES TOGETHER

Instructions:

This case report is used by Child Death Review (CDR) 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 CDR 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 related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available.** It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

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

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

Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields**, do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital." **Why this reminder?** Text fields may be shared with approved researchers as noted in the Data Use Agreement in your state or jurisdiction. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP. This version includes the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

CASE NUMBER			
_____ State / County or Team Number / Year of Review / Sequence of Review	<table border="1"> <tr> <td> Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive (fetal/stillborn) <input type="checkbox"/> Child never left hospital following birth </td> <td> Death Certificate Number: _____ Birth Certificate Number: _____ ME/Coroner Number: _____ Date Team Notified of Death: _____ </td> </tr> </table>	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive (fetal/stillborn) <input type="checkbox"/> Child never left hospital following birth	Death Certificate Number: _____ Birth Certificate Number: _____ ME/Coroner Number: _____ Date Team Notified of Death: _____
Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive (fetal/stillborn) <input type="checkbox"/> Child never left hospital following birth	Death Certificate Number: _____ Birth Certificate Number: _____ ME/Coroner Number: _____ Date Team Notified of Death: _____		

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K									
2. Date of birth: <input type="checkbox"/> U/K		3. Date of death: <input type="checkbox"/> U/K		4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K		5. Race, check all that apply: <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> Alaska Native, Tribe: _____			
6. Hispanic or Latino origin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K		8. Residence address: <input type="checkbox"/> U/K			9. Child's weight at death: <input type="checkbox"/> U/K		
Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____			<input type="radio"/> Pounds/ounces _____ <input type="radio"/> Grams/kilograms _____			11. State of death: _____			
10. Child's height at death: <input type="checkbox"/> U/K			12. County of death: _____		13. Child had disability or chronic illness? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		15. Child's health insurance, check all that apply:		
If yes, check all that apply: <input type="checkbox"/> Physical/orthopedic, specify: _____ <input type="checkbox"/> Mental health/substance abuse, specify: _____ <input type="checkbox"/> Cognitive/intellectual, specify: _____ <input type="checkbox"/> Sensory, specify: _____ <input type="checkbox"/> U/K			If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			<input type="checkbox"/> None <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Private <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Medicaid <input type="checkbox"/> U/K <input type="checkbox"/> State plan		16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule? <input type="radio"/> NA <input type="radio"/> Yes <input type="radio"/> No, specify: _____ <input type="radio"/> U/K	
14. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K				If the child never left the hospital following birth, go to A2.					

17. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: _____ <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K				18. New residence in past 30 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		19. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		21. Number of other children living with child: _____ <input type="checkbox"/> U/K			
22. Child had history of child maltreatment? If yes, check all that apply:				20. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		23. Was there an open CPS case with child at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		24. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
<u>As Victim</u> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<u>As Perpetrator</u> <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K		If yes, how was history identified: <input type="radio"/> Through CPS <input type="radio"/> Other sources If through CPS: <u>As Victim</u> _____ # CPS referrals <u>As Perpetrator</u> _____ # Substantiations				25. How many months prior to death did child last have contact with a health care provider? _____			

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

26. Child's highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate/GED <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: _____ <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12		27. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K		28. Did child have problems in school? <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"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K		29. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	
---	--	--	--	--	--	---	--

<p>30. Child had received prior mental health services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <input type="checkbox"/> Outpatient <input type="checkbox"/> Day treatment/partial hospitalization <input type="checkbox"/> Residential	<p>32. Child on medications for mental health illness? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>33. Child had emergency department visit for mental health care within the previous 12 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, did the child have a follow-up mental health appointment within 30 days of emergency department visit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>34. Child was hospitalized for mental health care within the previous 12 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, did the child have a follow-up MH appointment within 30 days of discharge from the hospital? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>35. Issues prevented child from receiving mental health services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>
<p>31. Child was receiving mental health services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <input type="checkbox"/> Outpatient <input type="checkbox"/> Day treatment/partial hospitalization <input type="checkbox"/> Residential		

<p>36. Child had history of substance use or abuse? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <input type="checkbox"/> Alcohol <input type="checkbox"/> Prescription drugs, specify: <input type="checkbox"/> Cocaine <input type="checkbox"/> Over-the-counter drugs, specify: <input type="checkbox"/> Marijuana <input type="checkbox"/> Tobacco/nicotine, specify type: <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify: <input type="checkbox"/> Opioids <input type="checkbox"/> U/K <p>If yes, did the child receive treatment? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, type? Check all that apply:</p> <input type="checkbox"/> Outpatient <input type="checkbox"/> Day treatment/partial hospitalization <input type="checkbox"/> Inpatient/detox <input type="checkbox"/> Residential	<p>37. Child had delinquent or criminal history? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> U/K <p>38. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>39. Child acutely ill in the two weeks before death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>40. What was child's gender identity? <input type="radio"/> No identity expressed <input type="radio"/> Non-binary <input type="radio"/> Male, not transgender <input type="radio"/> Other, specify: <input type="radio"/> Female, not transgender <input type="radio"/> Transgender male <input type="radio"/> U/K <input type="radio"/> Transgender female</p> <p>41. What was child's sexual orientation? <input type="radio"/> No orientation expressed <input type="radio"/> Other, specify: <input type="radio"/> Straight/heterosexual <input type="radio"/> Gay/lesbian <input type="radio"/> U/K <input type="radio"/> Bisexual <input type="radio"/> Questioning</p>
---	--	---

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

<p>42. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>				
<p>43. Gestational age: <input type="checkbox"/> U/K _____ # weeks</p>	<p>44. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____/_____</p>	<p>45. Multiple gestation? <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K</p>	<p>46. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K</p>	<p>47. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K</p>
<p>48. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K</p>	<p>49. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, number of prenatal visits kept: # _____ <input type="checkbox"/> U/K</p> <p>If yes, month of first prenatal visit. Specify 1-9: _____ <input type="checkbox"/> U/K</p>			

50. Were there access or compliance issues related to prenatal care? Yes No 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	

51. During pregnancy, did mother have any medical conditions/complications? Yes No U/K If yes, check all that apply:

<input type="checkbox"/> <u>Cardiovascular</u> <input type="checkbox"/> Hypertension - gestational <input type="checkbox"/> Hypertension - chronic <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Clotting disorder	<input type="checkbox"/> <u>Endocrine/Metabolic</u> <input type="checkbox"/> Diabetes, type 1 chronic <input type="checkbox"/> Diabetes, type 2 chronic <input type="checkbox"/> Diabetes, gestational <input type="checkbox"/> Thyroid <input type="checkbox"/> Polycystic ovarian disease	<input type="checkbox"/> <u>Sexually Transmitted Infection (STI)</u> <input type="checkbox"/> Bacterial vaginosis (BV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> HPV <input type="checkbox"/> Syphilis <input type="checkbox"/> Group B strep <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other STI, specify:	<input type="checkbox"/> <u>Gynecologic (continued)</u> <input type="checkbox"/> Intrauterine growth restriction (IUGR) <input type="checkbox"/> Premature rupture of membranes (PROM) <input type="checkbox"/> Preterm premature rupture of membranes (PPROM) <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> Umbilical cord complications <input type="checkbox"/> Prolapse <input type="checkbox"/> Nuchal cord <input type="checkbox"/> Other cord, specify:
<input type="checkbox"/> <u>Hematologic</u> <input type="checkbox"/> Folic acid deficiency <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Anemia (iron deficiency)	<input type="checkbox"/> <u>Neurologic/Psychiatric</u> <input type="checkbox"/> Addiction disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Seizure disorder	<input type="checkbox"/> <u>Gynecologic</u> <input type="checkbox"/> Uterine/vaginal bleeding <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Placental problems <input type="checkbox"/> Abruptio <input type="checkbox"/> Previa <input type="checkbox"/> Other placental, specify:

51. Mother's medical conditions (continued) <input type="checkbox"/> Other Condition/Complication <input type="checkbox"/> UTI <input type="checkbox"/> HELLP syndrome <input type="checkbox"/> Oral health/dental or gum infection <input type="checkbox"/> Maternal genetic disorder <input type="checkbox"/> Preterm labor <input type="checkbox"/> Decreased fetal movement <input type="checkbox"/> Maternal developmental delay <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Abnormal MSAFP <input type="checkbox"/> Other, specify:																								
52. 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)																								
53. 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"/> Meds to treat drug addiction <input type="checkbox"/> Allergy medications <input type="checkbox"/> Anti-hypertensives <input type="checkbox"/> Cholesterol medications <input type="checkbox"/> Heroin <input type="checkbox"/> Opioids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Anti-hypothyroidism <input type="checkbox"/> Sleeping pills <input type="checkbox"/> Marijuana <input type="checkbox"/> Other pain meds <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"/> Other, specify: <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"/> U/K <input type="checkbox"/> Asthma medications <input type="checkbox"/> Progesterone/P17 <input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome? If any item is checked, please indicate the generic or brand name of the medications or drugs:																								
54. Was the infant born drug exposed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
55. Did the infant have neonatal abstinence syndrome (NAS)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
56. 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		57. 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																						
		58. Did the mother attend a postpartum visit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																						
		59. 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"/> Hypothermia <input type="checkbox"/> Meconium aspiration <input type="checkbox"/> Low birth weight <input type="checkbox"/> Sepsis <input type="checkbox"/> Jaundice <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Tachypnea <input type="checkbox"/> Feeding difficulties <input type="checkbox"/> Anemia <input type="checkbox"/> Other, specify: <input type="checkbox"/> Drug/alcohol exposure <input type="checkbox"/> U/K																						
60. 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		61. Did the mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <table border="0"> <tr> <td></td> <td style="text-align: center;">Trimester 1</td> <td style="text-align: center;">Trimester 2</td> <td style="text-align: center;">Trimester 3</td> <td></td> </tr> <tr> <td>If yes,</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: right;">Avg # cigarettes/day</td> </tr> <tr> <td></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: right;">(20 cigarettes in pack)</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">U/K quantity</td> </tr> </table>				Trimester 1	Trimester 2	Trimester 3		If yes,	_____	_____	_____	Avg # cigarettes/day		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(20 cigarettes in pack)					U/K quantity
	Trimester 1	Trimester 2	Trimester 3																					
If yes,	_____	_____	_____	Avg # cigarettes/day																				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(20 cigarettes in pack)																				
				U/K quantity																				
62. Did the mother use e-cigarettes or other electronic nicotine products at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, on average how often? <input type="radio"/> More than once a day <input type="radio"/> Once a day <input type="radio"/> 2-6 days a week <input type="radio"/> 1 day a week or less <input type="radio"/> U/K																								
63. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:			64. 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 B.																								
65. 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		66. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> N/A <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 B.																								
67. 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		68. 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																						
69. 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:	70. 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:	71. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name and last dose given:	72. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula, type: <input type="checkbox"/> Baby food, type: <input type="checkbox"/> Cereal, type: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																					

B. BIOLOGICAL PARENT INFORMATION

No information available, go to Section C

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions. <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> <td><input type="radio"/> U/K</td> </tr> </table>		<u>Female</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K	<u>Male</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K																																																																																																																					
<u>Female</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K																																																																																																																											
<u>Male</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K																																																																																																																											
2. Parents' race, check all that apply: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>White</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Black</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Asian, specify:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>American Indian, Tribe:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Alaska Native, Tribe:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Native Hawaiian</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Pacific Islander, specify:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	White	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Black	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Asian, specify:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	American Indian, Tribe:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Alaska Native, Tribe:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Native Hawaiian	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Pacific Islander, specify:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K	3. Parents' Hispanic or Latino origin? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes, specify origin:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes, specify origin:	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	5. Parents' employment status: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Employed</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Unemployed</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>On disability</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Stay-at-home</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Retired</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Employed	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Unemployed	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	On disability	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Stay-at-home	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Retired	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																							
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	White																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Black																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Asian, specify:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	American Indian, Tribe:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Alaska Native, Tribe:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Native Hawaiian																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Pacific Islander, specify:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes, specify origin:																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Employed																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Unemployed																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	On disability																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Stay-at-home																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Retired																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
4. Parents' age in years at time of child's death: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td style="text-align:right;"><u>Male</u></td> <td></td> </tr> <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> </table>		<u>Female</u>	<u>Male</u>		_____	_____	# Years	<input type="checkbox"/>	<input type="checkbox"/>	U/K	6. Parents' income: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>High</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Medium</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Low</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	High	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Medium	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Low	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																															
<u>Female</u>	<u>Male</u>																																																																																																																													
_____	_____	# Years																																																																																																																												
<input type="checkbox"/>	<input type="checkbox"/>	U/K																																																																																																																												
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	High																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Medium																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Low																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
7. Parents' education: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>< High school</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>High school/ GED</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>College</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Post graduate</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	< High school	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	High school/ GED	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	College	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Post graduate	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	8. Parents speak and understand English? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If no, language spoken:	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	9. Parents first generation immigrant? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes, country of origin:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes, country of origin:	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	11. Parents receive social services in the past twelve months? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> <td>If yes, check all that apply below:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> <td></td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> <td></td> </tr> </table> <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>WIC</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Home visiting, specify:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>TANF</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Medicaid</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Food stamps/ SNAP/EBT</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Section 8/housing</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Social Security Disability Insurance (SSI/SSDI)</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	If yes, check all that apply below:	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No		<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K		<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	WIC	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Home visiting, specify:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	TANF	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Medicaid	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Food stamps/ SNAP/EBT	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Section 8/housing	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Social Security Disability Insurance (SSI/SSDI)	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other, specify:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K					
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	< High school																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	High school/ GED																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	College																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Post graduate																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes, country of origin:																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	If yes, check all that apply below:																																																																																																																									
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	WIC																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Home visiting, specify:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	TANF																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Medicaid																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Food stamps/ SNAP/EBT																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Section 8/housing																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Social Security Disability Insurance (SSI/SSDI)																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other, specify:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K																																																																																																																										
12. Parents have substance abuse history? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, check all that apply: <table style="width:100%; border:none;"> <tr><td><input type="checkbox"/></td><td>Alcohol</td></tr> <tr><td><input type="checkbox"/></td><td>Cocaine</td></tr> <tr><td><input type="checkbox"/></td><td>Marijuana</td></tr> <tr><td><input type="checkbox"/></td><td>Methamphetamine</td></tr> <tr><td><input type="checkbox"/></td><td>Opioids</td></tr> <tr><td><input type="checkbox"/></td><td>Prescription drugs</td></tr> <tr><td><input type="checkbox"/></td><td>Over-the-counter</td></tr> <tr><td><input type="checkbox"/></td><td>Other, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>U/K</td></tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Methamphetamine	<input type="checkbox"/>	Opioids	<input type="checkbox"/>	Prescription drugs	<input type="checkbox"/>	Over-the-counter	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	U/K	13. Parents ever victim of child maltreatment? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, check all that apply: <table style="width:100%; border:none;"> <tr><td><input type="checkbox"/></td><td>Physical</td></tr> <tr><td><input type="checkbox"/></td><td>Neglect</td></tr> <tr><td><input type="checkbox"/></td><td>Sexual</td></tr> <tr><td><input type="checkbox"/></td><td>Emotional/psychological</td></tr> <tr><td><input type="checkbox"/></td><td>U/K</td></tr> </table> _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> Ever in foster care or adopted	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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	14. Parents ever perpetrator of maltreatment? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, check all that apply: <table style="width:100%; border:none;"> <tr><td><input type="checkbox"/></td><td>Physical</td></tr> <tr><td><input type="checkbox"/></td><td>Neglect</td></tr> <tr><td><input type="checkbox"/></td><td>Sexual</td></tr> <tr><td><input type="checkbox"/></td><td>Emotional/psychological</td></tr> <tr><td><input type="checkbox"/></td><td>U/K</td></tr> </table> _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> CPS prevention services <input type="checkbox"/> Family preservation services <input type="checkbox"/> Children ever removed	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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	15. Parents have disability or chronic illness? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, check all that apply: <table style="width:100%; border:none;"> <tr><td><input type="checkbox"/></td><td>Physical/orthopedic, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>Mental health/substance abuse, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>Cognitive/intellectual, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>Sensory, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>U/K</td></tr> </table> If mental health/substance abuse, was parent receiving mental health services? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<input type="checkbox"/>	Alcohol																																																																																																																													
<input type="checkbox"/>	Cocaine																																																																																																																													
<input type="checkbox"/>	Marijuana																																																																																																																													
<input type="checkbox"/>	Methamphetamine																																																																																																																													
<input type="checkbox"/>	Opioids																																																																																																																													
<input type="checkbox"/>	Prescription drugs																																																																																																																													
<input type="checkbox"/>	Over-the-counter																																																																																																																													
<input type="checkbox"/>	Other, specify:																																																																																																																													
<input type="checkbox"/>	U/K																																																																																																																													
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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																																																																																																																													
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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																																																																																																																													
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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																																																																																																																													
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
16. Parents have prior child deaths? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, cause(s): Check all that apply: <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Child abuse # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Child neglect # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Accident # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Suicide # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>SIDS # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Undetermined cause # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Other # _____</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>				<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Child abuse # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Child neglect # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Accident # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Suicide # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	SIDS # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Undetermined cause # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other # _____	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other, specify:	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K																																																															
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	U/K																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Child abuse # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Child neglect # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Accident # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Suicide # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	SIDS # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Undetermined cause # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other # _____																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Other, specify:																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K																																																																																																																										
17. Parents have history of intimate partner violence? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Yes, as victim</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>Yes, as perpetrator</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="checkbox"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Yes, as victim	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Yes, as perpetrator	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	No	<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K	18. Parents have delinquent/criminal history? <table style="width:100%; border:none;"> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td style="text-align:right;"><u>Female</u></td> <td><input type="radio"/></td> <td style="text-align:right;"><u>Male</u></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> If yes, check all that apply: <table style="width:100%; border:none;"> <tr><td><input type="checkbox"/></td><td>Assaults</td></tr> <tr><td><input type="checkbox"/></td><td>Robbery</td></tr> <tr><td><input type="checkbox"/></td><td>Drugs</td></tr> <tr><td><input type="checkbox"/></td><td>Other, specify:</td></tr> <tr><td><input type="checkbox"/></td><td>U/K</td></tr> </table>	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No	<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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																																																																																
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Yes, as victim																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	Yes, as perpetrator																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	No																																																																																																																										
<u>Female</u>	<input type="checkbox"/>	<u>Male</u>	<input type="checkbox"/>	U/K																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	Yes																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<input type="radio"/>	No																																																																																																																										
<u>Female</u>	<input type="radio"/>	<u>Male</u>	<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

<p>1. Primary caregiver(s): Select only one each in columns one and two.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Self, go to Section D</td> <td><input type="radio"/></td> <td>Foster parent</td> <td><input type="radio"/></td> <td>Other relative</td> </tr> <tr> <td><input type="radio"/></td> <td>Biological mother, go to Section D</td> <td><input type="radio"/></td> <td>Mother's partner</td> <td><input type="radio"/></td> <td>Friend</td> </tr> <tr> <td><input type="radio"/></td> <td>Biological father, go to Section D</td> <td><input type="radio"/></td> <td>Father's partner</td> <td><input type="radio"/></td> <td>Institutional staff</td> </tr> <tr> <td><input type="radio"/></td> <td>Adoptive parent</td> <td><input type="radio"/></td> <td>Grandparent</td> <td><input type="radio"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td>Stepparent</td> <td><input type="radio"/></td> <td>Sibling</td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>						<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	Self, go to Section D	<input type="radio"/>	Foster parent	<input type="radio"/>	Other relative	<input type="radio"/>	Biological mother, go to Section D	<input type="radio"/>	Mother's partner	<input type="radio"/>	Friend	<input type="radio"/>	Biological father, go to Section D	<input type="radio"/>	Father's partner	<input type="radio"/>	Institutional staff	<input type="radio"/>	Adoptive parent	<input type="radio"/>	Grandparent	<input type="radio"/>	Other, specify:	<input type="radio"/>	Stepparent	<input type="radio"/>	Sibling	<input type="radio"/>	U/K	<p>2. Caregiver(s) age in years:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>_____</td> <td>_____</td> <td># Years</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> <td></td> <td></td> <td></td> </tr> </table>		<u>One</u>	<u>Two</u>					_____	_____	# Years				<input type="checkbox"/>	<input type="checkbox"/>	U/K																													
<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>																																																																																		
<input type="radio"/>	Self, go to Section D	<input type="radio"/>	Foster parent	<input type="radio"/>	Other relative																																																																																		
<input type="radio"/>	Biological mother, go to Section D	<input type="radio"/>	Mother's partner	<input type="radio"/>	Friend																																																																																		
<input type="radio"/>	Biological father, go to Section D	<input type="radio"/>	Father's partner	<input type="radio"/>	Institutional staff																																																																																		
<input type="radio"/>	Adoptive parent	<input type="radio"/>	Grandparent	<input type="radio"/>	Other, specify:																																																																																		
<input type="radio"/>	Stepparent	<input type="radio"/>	Sibling	<input type="radio"/>	U/K																																																																																		
<u>One</u>	<u>Two</u>																																																																																						
_____	_____	# Years																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	U/K																																																																																					
<p>4. Caregiver(s) race, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td>White</td> <td><input type="checkbox"/></td> <td>Native Hawaiian</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Black</td> <td><input type="checkbox"/></td> <td>Pacific Islander, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Asian, specify:</td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td>American Indian, Tribe:</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Alaska Native, Tribe:</td> <td><input type="checkbox"/></td> <td></td> </tr> </table>			<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	White	<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Black	<input type="checkbox"/>	Pacific Islander, specify:	<input type="checkbox"/>	Asian, specify:	<input type="checkbox"/>	U/K	<input type="checkbox"/>	American Indian, Tribe:	<input type="checkbox"/>		<input type="checkbox"/>	Alaska Native, Tribe:	<input type="checkbox"/>		<p>5. Caregiver(s) Hispanic or Latino origin?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, specify origin:</p>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<input type="radio"/>	U/K	<p>6. Caregiver(s) employment status:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Employed</td> </tr> <tr> <td><input type="radio"/></td> <td>Unemployed</td> </tr> <tr> <td><input type="radio"/></td> <td>On disability</td> </tr> <tr> <td><input type="radio"/></td> <td>Stay-at-home</td> </tr> <tr> <td><input type="radio"/></td> <td>Retired</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Employed	<input type="radio"/>	Unemployed	<input type="radio"/>	On disability	<input type="radio"/>	Stay-at-home	<input type="radio"/>	Retired	<input type="radio"/>	U/K	<p>7. Caregiver(s) income:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>High</td> </tr> <tr> <td><input type="radio"/></td> <td>Medium</td> </tr> <tr> <td><input type="radio"/></td> <td>Low</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	High	<input type="radio"/>	Medium	<input type="radio"/>	Low	<input type="radio"/>	U/K																							
<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>																																																																																				
<input type="checkbox"/>	White	<input type="checkbox"/>	Native Hawaiian																																																																																				
<input type="checkbox"/>	Black	<input type="checkbox"/>	Pacific Islander, specify:																																																																																				
<input type="checkbox"/>	Asian, specify:	<input type="checkbox"/>	U/K																																																																																				
<input type="checkbox"/>	American Indian, Tribe:	<input type="checkbox"/>																																																																																					
<input type="checkbox"/>	Alaska Native, Tribe:	<input type="checkbox"/>																																																																																					
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Employed																																																																																						
<input type="radio"/>	Unemployed																																																																																						
<input type="radio"/>	On disability																																																																																						
<input type="radio"/>	Stay-at-home																																																																																						
<input type="radio"/>	Retired																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	High																																																																																						
<input type="radio"/>	Medium																																																																																						
<input type="radio"/>	Low																																																																																						
<input type="radio"/>	U/K																																																																																						
<p>8. Caregiver(s) education:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>< High school</td> </tr> <tr> <td><input type="radio"/></td> <td>High school/GED</td> </tr> <tr> <td><input type="radio"/></td> <td>College</td> </tr> <tr> <td><input type="radio"/></td> <td>Post graduate</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	< High school	<input type="radio"/>	High school/GED	<input type="radio"/>	College	<input type="radio"/>	Post graduate	<input type="radio"/>	U/K	<p>9. Do caregiver(s) speak and understand English?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If no, language spoken:</p>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<input type="radio"/>	U/K	<p>10. Caregiver(s) first generation immigrant?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes, country of origin:</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes, country of origin:	<input type="radio"/>	No	<input type="radio"/>	U/K	<p>12. Caregiver(s) receive social services in the past twelve months?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> <td>If yes, check all that apply below:</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td>WIC</td> <td><input type="checkbox"/></td> <td>Food stamps/SNAP/EBT</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Home visiting</td> <td><input type="checkbox"/></td> <td>Section 8/housing</td> </tr> <tr> <td></td> <td>specify:</td> <td><input type="checkbox"/></td> <td>Soc Sec Disability (SSI/SSDI)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>TANF</td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Medicaid</td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>					<input type="radio"/>	Yes	If yes, check all that apply below:				<input type="radio"/>	No					<input type="radio"/>	U/K					<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	WIC	<input type="checkbox"/>	Food stamps/SNAP/EBT	<input type="checkbox"/>	Home visiting	<input type="checkbox"/>	Section 8/housing		specify:	<input type="checkbox"/>	Soc Sec Disability (SSI/SSDI)	<input type="checkbox"/>	TANF	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	U/K				
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	< High school																																																																																						
<input type="radio"/>	High school/GED																																																																																						
<input type="radio"/>	College																																																																																						
<input type="radio"/>	Post graduate																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes, country of origin:																																																																																						
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes	If yes, check all that apply below:																																																																																					
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>																																																																																				
<input type="checkbox"/>	WIC	<input type="checkbox"/>	Food stamps/SNAP/EBT																																																																																				
<input type="checkbox"/>	Home visiting	<input type="checkbox"/>	Section 8/housing																																																																																				
	specify:	<input type="checkbox"/>	Soc Sec Disability (SSI/SSDI)																																																																																				
<input type="checkbox"/>	TANF	<input type="checkbox"/>	Other, specify:																																																																																				
<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	U/K																																																																																				
<p>13. Caregiver(s) have substance abuse history?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/></td> <td>Alcohol</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Cocaine</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Marijuana</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Methamphetamine</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Opioids</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Prescription drugs</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Over-the-counter</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<input type="radio"/>	U/K	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Methamphetamine	<input type="checkbox"/>	Opioids	<input type="checkbox"/>	Prescription drugs	<input type="checkbox"/>	Over-the-counter	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	U/K	<p>14. Caregiver(s) ever victim of child maltreatment?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/></td> <td>Physical</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Neglect</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Sexual</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Emotional/psychological</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care or adopted</p>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<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>15. Caregiver(s) ever perpetrator of maltreatment?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/></td> <td>Physical</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Neglect</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Sexual</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Emotional/psychological</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</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>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<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>16. Caregiver(s) have disability or chronic illness?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/></td> <td>Physical/orthopedic, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Mental health/substance abuse, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Cognitive/intellectual, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Sensory, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table> <p>If mental health/substance abuse, was caregiver receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<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
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<input type="checkbox"/>	Alcohol																																																																																						
<input type="checkbox"/>	Cocaine																																																																																						
<input type="checkbox"/>	Marijuana																																																																																						
<input type="checkbox"/>	Methamphetamine																																																																																						
<input type="checkbox"/>	Opioids																																																																																						
<input type="checkbox"/>	Prescription drugs																																																																																						
<input type="checkbox"/>	Over-the-counter																																																																																						
<input type="checkbox"/>	Other, specify:																																																																																						
<input type="checkbox"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<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																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<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																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<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																																																																																						
<p>17. Caregiver(s) have prior child deaths?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<input type="radio"/>	U/K	<p>If yes, cause(s): Check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Child abuse # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Child neglect # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Accident # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Suicide # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>SIDS # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Undetermined cause # _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Other # _____</td> </tr> <tr> <td></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="checkbox"/>	Child abuse # _____	<input type="checkbox"/>	Child neglect # _____	<input type="checkbox"/>	Accident # _____	<input type="checkbox"/>	Suicide # _____	<input type="checkbox"/>	SIDS # _____	<input type="checkbox"/>	Undetermined cause # _____	<input type="checkbox"/>	Other # _____		Other, specify:	<input type="checkbox"/>	U/K	<p>18. Caregiver(s) have history of intimate partner violence?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Yes, as victim</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Yes, as perpetrator</td> </tr> <tr> <td><input type="checkbox"/></td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="checkbox"/>	Yes, as victim	<input type="checkbox"/>	Yes, as perpetrator	<input type="checkbox"/>	No	<input type="checkbox"/>	U/K	<p>19. Caregiver(s) have delinquent/criminal history?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><u>One</u></td> <td style="width:15%;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/></td> <td>Assaults</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Robbery</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Drugs</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	Yes	<input type="radio"/>	No	<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																								
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<input type="radio"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="checkbox"/>	Child abuse # _____																																																																																						
<input type="checkbox"/>	Child neglect # _____																																																																																						
<input type="checkbox"/>	Accident # _____																																																																																						
<input type="checkbox"/>	Suicide # _____																																																																																						
<input type="checkbox"/>	SIDS # _____																																																																																						
<input type="checkbox"/>	Undetermined cause # _____																																																																																						
<input type="checkbox"/>	Other # _____																																																																																						
	Other, specify:																																																																																						
<input type="checkbox"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="checkbox"/>	Yes, as victim																																																																																						
<input type="checkbox"/>	Yes, as perpetrator																																																																																						
<input type="checkbox"/>	No																																																																																						
<input type="checkbox"/>	U/K																																																																																						
<u>One</u>	<u>Two</u>																																																																																						
<input type="radio"/>	Yes																																																																																						
<input type="radio"/>	No																																																																																						
<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																																																																																						

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"/> Opioids</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 mental health 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>
---	--	--	--

E. INCIDENT INFORMATION

<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> <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:</p> <p><input type="checkbox"/> Relative's home <input type="checkbox"/> Licensed child care home <input type="checkbox"/> Military installation <input type="checkbox"/> Other parking area</p> <p><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</p> <p><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</p> <p><input type="checkbox"/> Relative foster care home <input type="checkbox"/> School <input type="checkbox"/> Roadway <input type="checkbox"/> Other recreation area</p> <p><input type="checkbox"/> Licensed group home <input type="checkbox"/> Place of work <input type="checkbox"/> Hospital</p>	<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>

5. Incident state:	6. Incident county:	
7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death: If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):		
8. Was the incident witnessed? <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:	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?		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"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opioids <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs <input type="checkbox"/> Other, specify:
If yes, type of resuscitation: <input type="checkbox"/> EMS <input type="checkbox"/> Parent/relative <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 <input type="checkbox"/> Stranger <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:
If yes, how many shocks were administered? _____ <input type="checkbox"/> Rescue medications, specify type: <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"/> ME investigator <input type="checkbox"/> Law enforcement <input type="checkbox"/> EMS <input type="checkbox"/> Other, specify: <input type="checkbox"/> Coroner <input type="checkbox"/> Coroner investigator <input type="checkbox"/> Fire investigator <input type="checkbox"/> Child Protective Services <input type="checkbox"/> U/K If yes, which of the following death investigation components were completed? <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Narrative description of circumstances</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene photos</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation with doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation without doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Witness interviews</td> </tr> </table> </td> <td style="width:50%; border: none;"> If yes, shared with review team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No </td> </tr> </table> If yes, was a death scene investigation conducted at the place of incident? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Narrative description of circumstances</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene photos</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation with doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation without doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Witness interviews</td> </tr> </table>	<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"/> <input type="radio"/> <input type="radio"/>	Narrative description of circumstances	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene photos	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation with doll	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation without doll	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Witness interviews	If yes, shared with review team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No																					
<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Narrative description of circumstances</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene photos</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation with doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Scene recreation without doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Witness interviews</td> </tr> </table>	<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"/> <input type="radio"/> <input type="radio"/>	Narrative description of circumstances	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene photos	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation with doll	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation without doll	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Witness interviews	If yes, shared with review team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No																						
<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"/> <input type="radio"/> <input type="radio"/>	Narrative description of circumstances																																				
<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene photos																																				
<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation with doll																																				
<input type="radio"/> <input type="radio"/> <input type="radio"/>	Scene recreation without doll																																				
<input type="radio"/> <input type="radio"/> <input type="radio"/>	Witness interviews																																				
2. What additional information would the team like to have known about the death scene investigation?																																					
3. Death referred to: <input type="radio"/> Medical examiner <input type="radio"/> Not referred <input type="radio"/> Coroner <input type="radio"/> U/K	4. Person declaring official cause and manner of death: <input type="radio"/> Medical examiner <input type="radio"/> Hospital physician <input type="radio"/> Mortician <input type="radio"/> U/K <input type="radio"/> Coroner <input type="radio"/> Other physician <input type="radio"/> Other, specify:																																				
5. 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)?																																					
6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10. <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - single</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - multiple views</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - complete skeletal series</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):</td> </tr> </table> </td> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Exam of general appearance</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Head circumference</td> </tr> <tr> <td colspan="2">Other Autopsy Procedures:</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Was a gross examination of organs done?</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Were weights of any organs taken?</td> </tr> </table> </td> </tr> </table>	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - single</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - multiple views</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - complete skeletal series</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>		<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):	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Exam of general appearance</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Head circumference</td> </tr> <tr> <td colspan="2">Other Autopsy Procedures:</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Was a gross examination of organs done?</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Were weights of any organs taken?</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>		<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?	7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10. <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Cultures for infectious disease</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Microscopic/histologic exam</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Postmortem metabolic screen</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Vitreous testing</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Genetic testing</td> </tr> </table>	<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
<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - single</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - multiple views</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>X-ray - complete skeletal series</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>		<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):	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u> <u>No</u> <u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Exam of general appearance</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Head circumference</td> </tr> <tr> <td colspan="2">Other Autopsy Procedures:</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Was a gross examination of organs done?</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Were weights of any organs taken?</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>		<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?														
<u>Yes</u> <u>No</u> <u>U/K</u>																																					
<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):																																				
<u>Yes</u> <u>No</u> <u>U/K</u>																																					
<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?																																				
<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																																				

8. 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"/> Opioids <input type="checkbox"/> Too high OTC drug, specify: <input type="checkbox"/> U/K		
9. 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		10. Describe any abnormalities or other significant findings noted in the autopsy:
11. What additional information would the team like to have known about the autopsy?	12. Was there agreement between the cause of death listed on the autopsy 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. Was a CPS record check conducted as a result of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
14. 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	15. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated	16. 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

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 <input type="checkbox"/> If manner of death was not Natural or Suicide, check this box if it is possible that the child intended to hurt him/herself. If checked, complete the Suicide Section (I6) to note other risk factors in the child's life.	6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause. <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 I1 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I1
--	---

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><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:	
<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																																																																																																																	
<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																																																																																																																		
<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:																																																																																																																			
<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																																																																																					
<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																																																																																																																			
<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																																																																																																																		

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>
--	---

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			
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 less sides <input type="radio"/> Three 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	
<p>H4. UNINTENTIONAL ASPHYXIA</p>				
<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, specify: <input type="radio"/> Plastic bag <input type="radio"/> Toy chest <input type="radio"/> Automobile <input type="radio"/> Asphyxia by gas, go to H7g <input type="radio"/> Dirt/sand <input type="radio"/> Trunk <input type="radio"/> Other, specify: _____ <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>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>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>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

a. Type of weapon: <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	b. For firearms, type: <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	c. Firearm licensed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Firearm safety features, check all that apply: <input type="checkbox"/> Trigger lock <input type="checkbox"/> Personalization device <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K
e. Where was firearm stored? <input type="radio"/> Not stored <input type="radio"/> Locked cabinet <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment			<input type="radio"/> Under mattress/pillow <input type="radio"/> Other, specify: <input type="radio"/> U/K
			f. Firearm stored with ammunition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
			g. Firearm stored loaded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

h. Owner of fatal firearm: <input type="radio"/> U/K, weapon stolen <input type="radio"/> U/K, weapon found <input type="radio"/> Self <input type="radio"/> Biological parent <input type="radio"/> Adoptive parent <input type="radio"/> Stepparent <input type="radio"/> Foster parent <input type="radio"/> Mother's partner <input type="radio"/> Father's partner <input type="radio"/> Grandparent <input type="radio"/> Sibling <input type="radio"/> Spouse <input type="radio"/> Other relative <input type="radio"/> Friend <input type="radio"/> Acquaintance <input type="radio"/> Child's boyfriend or girlfriend <input type="radio"/> Classmate <input type="radio"/> Co-worker <input type="radio"/> Institutional staff <input type="radio"/> Neighbor <input type="radio"/> Rival gang member <input type="radio"/> Stranger <input type="radio"/> Law enforcement <input type="radio"/> Other, specify: <input type="radio"/> U/K	i. Sex of fatal firearm owner: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	j. Type of sharp object: <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	k. Type of blunt object: <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
---	--	--	---

l. What did person's body part do? Check all that apply: <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	m. Did person using weapon have history of weapon-related offenses? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes? <input type="radio"/> Yes, describe circumstances: <input type="radio"/> No <input type="radio"/> U/K	o. Persons handling weapons at time of incident, check all that apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <u>Fatal and/or Other weapon</u> <input type="checkbox"/> Self <input type="checkbox"/> Biological parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother's partner <input type="checkbox"/> Father's partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other relative </td> <td style="width:50%; vertical-align: top;"> <u>Fatal and/or Other weapon</u> <input type="checkbox"/> Friend <input type="checkbox"/> Acquaintance <input type="checkbox"/> Child's boyfriend or girlfriend <input type="checkbox"/> Classmate <input type="checkbox"/> Co-worker <input type="checkbox"/> Institutional staff <input type="checkbox"/> Neighbor <input type="checkbox"/> Rival gang member <input type="checkbox"/> Stranger <input type="checkbox"/> Law enforcement officer <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K </td> </tr> </table>	<u>Fatal and/or Other weapon</u> <input type="checkbox"/> Self <input type="checkbox"/> Biological parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother's partner <input type="checkbox"/> Father's partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other relative	<u>Fatal and/or Other weapon</u> <input type="checkbox"/> Friend <input type="checkbox"/> Acquaintance <input type="checkbox"/> Child's boyfriend or girlfriend <input type="checkbox"/> Classmate <input type="checkbox"/> Co-worker <input type="checkbox"/> Institutional staff <input type="checkbox"/> Neighbor <input type="checkbox"/> Rival gang member <input type="checkbox"/> Stranger <input type="checkbox"/> Law enforcement officer <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	p. Sex of person(s) handling weapon: Fatal weapon: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K Other weapon: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
<u>Fatal and/or Other weapon</u> <input type="checkbox"/> Self <input type="checkbox"/> Biological parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother's partner <input type="checkbox"/> Father's partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other relative	<u>Fatal and/or Other weapon</u> <input type="checkbox"/> Friend <input type="checkbox"/> Acquaintance <input type="checkbox"/> Child's boyfriend or girlfriend <input type="checkbox"/> Classmate <input type="checkbox"/> Co-worker <input type="checkbox"/> Institutional staff <input type="checkbox"/> Neighbor <input type="checkbox"/> Rival gang member <input type="checkbox"/> Stranger <input type="checkbox"/> Law enforcement officer <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K				

q. Use of weapon at time, check all that apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;"><input type="checkbox"/> Self injury</td> <td style="width:20%;"><input type="checkbox"/> Child was a bystander</td> <td style="width:20%;"><input type="checkbox"/> Bullying</td> <td style="width:20%;"><input type="checkbox"/> Showing gun to others</td> <td style="width:20%;"><input type="checkbox"/> Loading weapon</td> </tr> <tr> <td><input type="checkbox"/> Commission of crime</td> <td><input type="checkbox"/> Argument</td> <td><input type="checkbox"/> Hunting</td> <td><input type="checkbox"/> Russian roulette</td> <td><input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)</td> </tr> <tr> <td><input type="checkbox"/> Drug dealing/trading</td> <td><input type="checkbox"/> Jealousy</td> <td><input type="checkbox"/> Target shooting</td> <td><input type="checkbox"/> Gang-related activity</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Drive-by shooting</td> <td><input type="checkbox"/> Intimate partner violence</td> <td><input type="checkbox"/> Playing with weapon</td> <td><input type="checkbox"/> Self-defense</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Random violence</td> <td><input type="checkbox"/> Hate crime</td> <td><input type="checkbox"/> Weapon mistaken for toy</td> <td><input type="checkbox"/> Cleaning weapon</td> <td></td> </tr> </table>					<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	
<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

a. Type: <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	b. Height of fall: _____ feet _____ inches <input type="checkbox"/> U/K	c. Child fell from: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; vertical-align: top;"> <input type="radio"/> Open window <input type="radio"/> Screen <input type="radio"/> No screen <input type="radio"/> U/K if screen Screen? </td> <td style="width:20%; vertical-align: top;"> <input type="radio"/> Natural elevation <input type="radio"/> Man-made elevation <input type="radio"/> Playground equipment <input type="radio"/> Tree </td> <td style="width:20%; vertical-align: top;"> <input type="radio"/> Stairs/steps <input type="radio"/> Furniture <input type="radio"/> Bed <input type="radio"/> Roof </td> <td style="width:20%; vertical-align: top;"> <input type="radio"/> Moving object, specify: <input type="radio"/> Bridge <input type="radio"/> Overpass <input type="radio"/> Balcony </td> <td style="width:20%; vertical-align: top;"> <input type="radio"/> Animal, specify: <input type="radio"/> Other, specify: <input type="radio"/> U/K </td> </tr> </table>					<input type="radio"/> Open window <input type="radio"/> Screen <input type="radio"/> No screen <input type="radio"/> U/K if screen Screen?	<input type="radio"/> Natural elevation <input type="radio"/> Man-made elevation <input type="radio"/> Playground equipment <input type="radio"/> Tree	<input type="radio"/> Stairs/steps <input type="radio"/> Furniture <input type="radio"/> Bed <input type="radio"/> Roof	<input type="radio"/> Moving object, specify: <input type="radio"/> Bridge <input type="radio"/> Overpass <input type="radio"/> Balcony	<input type="radio"/> Animal, specify: <input type="radio"/> Other, specify: <input type="radio"/> U/K
<input type="radio"/> Open window <input type="radio"/> Screen <input type="radio"/> No screen <input type="radio"/> U/K if screen Screen?	<input type="radio"/> Natural elevation <input type="radio"/> Man-made elevation <input type="radio"/> Playground equipment <input type="radio"/> Tree	<input type="radio"/> Stairs/steps <input type="radio"/> Furniture <input type="radio"/> Bed <input type="radio"/> Roof	<input type="radio"/> Moving object, specify: <input type="radio"/> Bridge <input type="radio"/> Overpass <input type="radio"/> Balcony	<input type="radio"/> Animal, specify: <input type="radio"/> Other, specify: <input type="radio"/> U/K							

<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Linoleum/vinyl <input type="radio"/> Grass <input type="radio"/> Marble/tile <input type="radio"/> Gravel <input type="radio"/> Other, specify: <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> U/K	<p>e. Barrier in place, check all that apply::</p> <input type="checkbox"/> None <input type="checkbox"/> Stairway <input type="checkbox"/> Screen <input type="checkbox"/> Gate <input type="checkbox"/> Other window guard <input type="checkbox"/> Other, specify: <input type="checkbox"/> Fence <input type="checkbox"/> U/K <input type="checkbox"/> Railing	<p>g. 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>h. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Boulders/rocks <input type="radio"/> Television <input type="radio"/> Dirt/sand <input type="radio"/> Furniture <input type="radio"/> Person, go to H5q <input type="radio"/> Walls <input type="radio"/> Commercial <input type="radio"/> Playground <input type="radio"/> equipment <input type="radio"/> equipment <input type="radio"/> Farm equipment <input type="radio"/> Animal <input type="radio"/> Other, specify: <input type="radio"/> Tree branch <input type="radio"/> U/K
<p>f. Was child pushed, dropped or thrown? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, go to H5q</p>			

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Source codes: 1 = Bought from dealer or stranger (Prescription or illicit only) 4 = Took from friend or relative without asking 7 = Other
2 = Bought from friend or relative 5 = Own prescription (Prescription only) 9 = U/K
3 = From friend or relative for free 6 = Bought from store/pharmacy (OTC or other substances only)

Prescription drug/source	Over-the-counter drug/source	Illicit drugs/source	Other substances/source
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Pain medication	<input type="checkbox"/> Pain medication (opioids)	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Pain medication (opioids)	<input type="checkbox"/> Cold medicine	<input type="checkbox"/> Pain medication (non-opioids)	<input type="checkbox"/> Carbon monoxide, go to e
<input type="checkbox"/> Pain medication (non-opioids)	<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		<input type="checkbox"/> Other illicit drug, specify:	

<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>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 If yes, who called: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Other caregiver <input type="radio"/> First responder <input type="radio"/> Medical person <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>g. For CO poisoning, was a CO alarm present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many? _____ Functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<p>d. Did container have a child safety cap? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>				

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 If yes, within 48 hours of the death? <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="checkbox"/> Appointments <input type="checkbox"/> Therapies, specify: <input type="radio"/> Yes <input type="checkbox"/> Medications, specify: <input type="radio"/> No <input type="checkbox"/> Medical equipment use, specify: <input type="radio"/> U/K <input type="checkbox"/> U/K	<p>f. Was the medical condition associated with an outbreak?</p> <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> 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> <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Couldn't get provider to take as patient <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Couldn't get an earlier appointment <input type="checkbox"/> No phone <input type="checkbox"/> Lack of child care <input type="checkbox"/> Cultural differences <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Language barriers <input type="checkbox"/> Services not available	<p>If yes, check all that apply:</p> <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> U/K <input type="checkbox"/> Caregiver unskilled in providing 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:	<p>i. Was death caused by a medical misadventure?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
---	--	--

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

I1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)

This section displays online based on your state's settings.

Section I1: OMB No. 0920-1092, Exp. Date: 4/30/2022

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

- a. Was this death:
- A homicide?
 - A suicide?
 - An overdose?
 - A result of an external cause that was the obvious and only reason for the fatal injury?
 - Expected within 6 months due to terminal illness?
 - None of the above, go to I1b THIS IS AN SDY CASE
 - U/K, go to I1b

If any of these apply, go to Section I2, THIS IS NOT AN SDY CASE.

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

U/K for all

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

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

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

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

Yes No U/K

If yes, describe:

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

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

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

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

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

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

Y N U/K **Deaths**

Sudden unexpected death before age 50

If yes, describe the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

Heart Disease

- Heart condition/heart attack or stroke before age 50
- Aortic aneurysm or aortic rupture
- Arrhythmia (fast or irregular heart rhythm)
- Cardiomyopathy
- Congenital heart disease

Neurologic Disease

- Epilepsy or convulsions/seizure
- Other neurologic disease

Y N U/K **Symptoms**

- Febrile seizures
- Unexplained fainting

Other Diagnoses

- Congenital deafness
- Connective tissue disease
- Mitochondrial disease
- Muscle disorder or muscular dystrophy
- Thrombophilia (clotting disorder)
- Other diseases that are genetic or run in families, specify:

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

Yes No U/K

If yes, describe the test/gene tested, reason for testing, family member tested, and results:

Was a gene mutation found?

Yes No U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?

Yes No U/K

If yes, describe:

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

N/A Yes No U/K

Taken extra doses of prescribed medications

Missed doses of prescribed medications

Changed prescribed medications, describe:

j. Was the child compliant with their prescribed medications?

N/A Yes No U/K

If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?

Check all that apply:

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

If yes to any items above, describe:

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

U/K for all within 24 hours of incident

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

If yes to physical activity, describe type of activity:

At incident Within 24 hours of incident

Other specify:

At incident Within 24 hours of incident

m. Was the child an athlete? N/A Yes No U/K

If yes, type of sport: Competitive Recreational U/K

If competitive, did the child participate in the 6 months prior to death? Yes No U/K

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

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

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

o. For child age 12 or older, did the child receive a pre-participation exam for a sport?

N/A Yes No U/K

If yes:

Was it done within a year prior to death? Yes No U/K

Did the exam lead to restrictions for sports or otherwise? Yes No U/K

If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)																
<p>p. How old was the child when diagnosed with epilepsy/seizure disorder? Age 0 (infant) through 20 years: _____ <input type="checkbox"/> U/K</p>	<p>r. What type(s) of seizures did the child have? Check all that apply:</p> <p><input type="checkbox"/> Non-convulsive <input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure) <input type="checkbox"/> Occur when exposure to strobe lights, video game, or flickering light (reflex seizure) <input type="checkbox"/> U/K</p>	<p>t. How many seizures did the child have in the year preceding death? <input type="radio"/> 0/never <input type="radio"/> 2 <input type="radio"/> More than 3 <input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> U/K</p>														
<p>q. What were the underlying cause(s) of the child's seizures? Check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> Brain injury/trauma, specify:</td> <td style="width:50%; border: none;"><input type="checkbox"/> Genetic/chromosomal</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Brain tumor</td> <td style="border: none;"><input type="checkbox"/> Mesial temporal sclerosis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cerebrovascular</td> <td style="border: none;"><input type="checkbox"/> Idiopathic or cryptogenic</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Central nervous system infection</td> <td style="border: none;"><input type="checkbox"/> Other acute illness or injury other than epilepsy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Degenerative process</td> <td style="border: none;"><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Developmental brain disorder</td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Inborn error of metabolism</td> <td></td> </tr> </table>	<input type="checkbox"/> Brain injury/trauma, specify:	<input type="checkbox"/> Genetic/chromosomal	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Mesial temporal sclerosis	<input type="checkbox"/> Cerebrovascular	<input type="checkbox"/> Idiopathic or cryptogenic	<input type="checkbox"/> Central nervous system infection	<input type="checkbox"/> Other acute illness or injury other than epilepsy	<input type="checkbox"/> Degenerative process	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Developmental brain disorder	<input type="checkbox"/> U/K	<input type="checkbox"/> Inborn error of metabolism		<p>s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:</p> <p><input type="checkbox"/> Last less than 30 minutes <input type="checkbox"/> Last more than 30 minutes (status epilepticus) <input type="checkbox"/> Occur in the presence of fever (febrile seizure) <input type="checkbox"/> Occur in the absence of fever <input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)</p>	<p>u. Did treatment for seizures include anti-epileptic drugs? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how many different types of anti-epileptic drugs did the child take? <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> More than 6 <input type="radio"/> U/K</p>
<input type="checkbox"/> Brain injury/trauma, specify:	<input type="checkbox"/> Genetic/chromosomal															
<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Mesial temporal sclerosis															
<input type="checkbox"/> Cerebrovascular	<input type="checkbox"/> Idiopathic or cryptogenic															
<input type="checkbox"/> Central nervous system infection	<input type="checkbox"/> Other acute illness or injury other than epilepsy															
<input type="checkbox"/> Degenerative process	<input type="checkbox"/> Other, specify:															
<input type="checkbox"/> Developmental brain disorder	<input type="checkbox"/> U/K															
<input type="checkbox"/> Inborn error of metabolism																
<p>v. Was night surveillance used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																

12. 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

<p>a. Incident sleep place:</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; border: none;"><input type="radio"/> Crib</td> <td style="width:25%; border: none;"><input type="radio"/> Adult bed</td> <td style="width:25%; border: none;"><input type="radio"/> Car seat</td> <td style="width:25%; border: none;">If adult bed, what type?</td> </tr> <tr> <td style="border: none;">If crib, type:</td> <td style="border: none;"><input type="radio"/> Waterbed</td> <td style="border: none;"><input type="radio"/> Rock 'n Play</td> <td style="border: none;"><input type="radio"/> Twin</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Not portable</td> <td style="border: none;"><input type="radio"/> Futon</td> <td style="border: none;"><input type="radio"/> Stroller</td> <td style="border: none;"><input type="radio"/> Full</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Portable, e.g. Pack 'n Play</td> <td style="border: none;"><input type="radio"/> Playpen/other play structure, not a portable crib</td> <td style="border: none;"><input type="radio"/> Swing</td> <td style="border: none;"><input type="radio"/> Queen</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Unknown crib type</td> <td style="border: none;"><input type="radio"/> Bouncy chair</td> <td style="border: none;"><input type="radio"/> Other, specify:</td> <td style="border: none;"><input type="radio"/> King</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Bassinet</td> <td style="border: none;"><input type="radio"/> Couch</td> <td style="border: none;"><input type="radio"/> U/K</td> <td style="border: none;">If futon, <input type="radio"/> Bed position</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Bed side sleeper</td> <td style="border: none;"><input type="radio"/> Chair</td> <td></td> <td style="border: none;"><input type="radio"/> Couch position</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Baby box</td> <td style="border: none;"><input type="radio"/> Floor</td> <td></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>				<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	If adult bed, what type?	If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Twin	<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Full	<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"/> Unknown crib type	<input type="radio"/> Bouncy chair	<input type="radio"/> Other, specify:	<input type="radio"/> King	<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> U/K	If futon, <input type="radio"/> Bed position	<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair		<input type="radio"/> Couch position	<input type="radio"/> Baby box	<input type="radio"/> Floor		<input type="radio"/> U/K
<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	If adult bed, what type?																																
If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Twin																																
<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Full																																
<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"/> Unknown crib type	<input type="radio"/> Bouncy chair	<input type="radio"/> Other, specify:	<input type="radio"/> King																																
<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> U/K	If futon, <input type="radio"/> Bed position																																
<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair		<input type="radio"/> Couch position																																
<input type="radio"/> Baby box	<input type="radio"/> Floor		<input type="radio"/> U/K																																

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

<p>d. Usual sleep place:</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; border: none;"><input type="radio"/> Crib</td> <td style="width:25%; border: none;"><input type="radio"/> Baby box</td> <td style="width:25%; border: none;"><input type="radio"/> Floor</td> <td style="width:25%; border: none;">If adult bed, what type?</td> </tr> <tr> <td style="border: none;">If crib, type:</td> <td style="border: none;"><input type="radio"/> Adult bed</td> <td style="border: none;"><input type="radio"/> Car seat</td> <td style="border: none;"><input type="radio"/> Twin</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Not portable</td> <td style="border: none;"><input type="radio"/> Waterbed</td> <td style="border: none;"><input type="radio"/> Rock 'n Play</td> <td style="border: none;"><input type="radio"/> Full</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Portable, e.g. Pack 'n Play</td> <td style="border: none;"><input type="radio"/> Futon</td> <td style="border: none;"><input type="radio"/> Stroller</td> <td style="border: none;"><input type="radio"/> Queen</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Unknown crib type</td> <td style="border: none;"><input type="radio"/> Playpen/other play structure, not a portable crib</td> <td style="border: none;"><input type="radio"/> Swing</td> <td style="border: none;"><input type="radio"/> King</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Bassinet</td> <td style="border: none;"><input type="radio"/> Bouncy chair</td> <td style="border: none;"><input type="radio"/> Other, specify:</td> <td style="border: none;"><input type="radio"/> Other, specify:</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Bed side sleeper</td> <td style="border: none;"><input type="radio"/> Couch</td> <td style="border: none;"><input type="radio"/> U/K</td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> <tr> <td></td> <td style="border: none;"><input type="radio"/> Chair</td> <td></td> <td style="border: none;">If futon, <input type="radio"/> Bed position</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="border: none;"><input type="radio"/> Couch position</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>				<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"/> Twin	<input type="radio"/> Not portable	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Full	<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Queen	<input type="radio"/> Unknown crib type	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> King	<input type="radio"/> Bassinet	<input type="radio"/> Bouncy chair	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> Bed side sleeper	<input type="radio"/> Couch	<input type="radio"/> U/K	<input type="radio"/> U/K		<input type="radio"/> Chair		If futon, <input type="radio"/> Bed position				<input type="radio"/> Couch position				<input type="radio"/> U/K
<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"/> Twin																																								
<input type="radio"/> Not portable	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Full																																								
<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Queen																																								
<input type="radio"/> Unknown crib type	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> King																																								
<input type="radio"/> Bassinet	<input type="radio"/> Bouncy chair	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:																																								
<input type="radio"/> Bed side sleeper	<input type="radio"/> Couch	<input type="radio"/> U/K	<input type="radio"/> U/K																																								
	<input type="radio"/> Chair		If futon, <input type="radio"/> Bed position																																								
			<input type="radio"/> Couch position																																								
			<input type="radio"/> U/K																																								

<p>g. Child in a new or different environment than usual? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe why:</p>	<p>h. Child last placed to sleep with a pacifier? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Child wrapped or swaddled in blanket? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:</p>
--	---	--

<p>j. Child overheated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, outside temp ____ degrees F Check all that apply:</p> <p><input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing</p>	<p>k. Child exposed to second hand smoke? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally</p>
--	--

<p>l. Child's face when found: <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K</p>	<p>m. Child's neck when found: <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>	<p>n. Child's airway when found (includes nose, mouth, neck and/or chest): <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>	<p>If fully or partially obstructed, what was obstructed? <input type="checkbox"/> Nose <input type="checkbox"/> Chest compressed <input type="checkbox"/> Mouth <input type="checkbox"/> U/K <input type="checkbox"/> Neck compressed</p> <p>If fully or partially obstructed, describe obstruction in detail:</p>
--	---	---	--

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

<p>q. Caregiver/supervisor fell asleep while feeding child?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> Breast <input type="radio"/> U/K</p>	<p>r. Child sleeping in the same room as caregiver/supervisor at time of death?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
---	---

<p>s. Child sleeping on same surface with person(s) or animal(s)?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>If yes, reasons stated for sleeping on same surface, check all that apply:</p> <p><input type="checkbox"/> To feed</p> <p><input type="checkbox"/> To soothe</p> <p><input type="checkbox"/> Usual sleep pattern</p> <p><input type="checkbox"/> No infant bed available</p> <p><input type="checkbox"/> Home/living space overcrowded</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>If yes, check all that apply:</p> <p><input type="checkbox"/> With adult(s): # _____ <input type="checkbox"/> # U/K</p> <p>Adult obese: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p><input type="checkbox"/> With other children: # _____ <input type="checkbox"/> # U/K Children's ages: _____</p> <p><input type="checkbox"/> With animal(s): # _____ <input type="checkbox"/> # U/K Type(s) of animal: _____</p>
---	---	--

t. 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:

<p>b. Was product used properly?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>c. Is a recall in place?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>d. Did product have safety label?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>e. Was Consumer Product Safety Commission (CPSC) notified?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, go to www.saferproducts.gov to report</p> <p><input type="radio"/> U/K</p>
--	---	--	--

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> <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> <p><input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Failure to provide supervision <input type="checkbox"/> Emotional neglect, specify: <input type="checkbox"/> Abandonment, specify: <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>	<p>g. Exposure to hazards: Do not include child's own behavior.</p> <p><input type="checkbox"/> Hazard(s) in sleep environment (including sleep position and surface sharing) <input type="checkbox"/> Fire hazard <input type="checkbox"/> Unsecured medication/poison <input type="checkbox"/> Firearm hazard <input type="checkbox"/> Water hazard <input type="checkbox"/> Motor vehicle hazard <input type="checkbox"/> Maternal substance use during pregnancy <input type="checkbox"/> Other hazard, specify:</p>	<p>h. Was poverty a factor? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, explain in Narrative</p>
--	--	---

I6. SUICIDE

<p>a. Child's history. Check all that have <u>ever</u> applied:</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Involved in sports <input type="checkbox"/> Involved in activities (not sports) <input type="checkbox"/> Viewed, posted or interacted on social media If yes, specify platform(s): <input type="checkbox"/> History of running away <input type="checkbox"/> History of fearfulness, withdrawal or anxiety <input type="checkbox"/> History of explosive anger, yelling or disobeying <input type="checkbox"/> History of head injury If yes, when was the last head injury? _____ <input type="checkbox"/> Death of a peer, friend or family member If yes, specify relationship to child: _____ When did death occur: _____ Was death a suicide? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>b. Was the child ever diagnosed with any of the following? Check all that apply.</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Anxiety spectrum disorder <input type="checkbox"/> Depressive spectrum disorder <input type="checkbox"/> Bipolar spectrum disorder <input type="checkbox"/> Disruptive, impulse control or conduct disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Substance-related or addictive disorders <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p> <p>c. Check all suicidal behaviors/attempts that ever applied:</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Interrupted attempt #__ <input type="checkbox"/> Preparatory behavior #__ <input type="checkbox"/> Non-fatal attempt #__ <input type="checkbox"/> Aborted attempt #__ <input type="checkbox"/> U/K</p>	<p>d. Did the child <u>ever</u> communicate any suicidal thoughts, actions or intent? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, with whom? _____</p> <p>e. Was there evidence the death was planned or premeditated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>f. Did the death occur under circumstances where it would likely be observed and intervened by others? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>g. Did the child ever have a history of non-suicidal self-harm, such as cutting or burning oneself? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, <input type="checkbox"/> Reported to others <input type="checkbox"/> Other, specify: <input type="checkbox"/> Noted on autopsy</p>
---	--	---

<p>h. Warning signs (https://youthsuicidewarningsigns.org) w/in 30 days of death. Check all that apply:</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Talked about or made plans for suicide <input type="checkbox"/> Expressed hopelessness about the future <input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress</p> <p><input type="checkbox"/> Expressed perceived burden on others <input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior <input type="checkbox"/> U/K</p>	<p>i. Child experienced a known crisis within 30 days of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, explain:</p>	<p>j. Suicide was part of: Check all that apply.</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> A suicide pact <input type="checkbox"/> A cluster <input type="checkbox"/> A murder-suicide <input type="checkbox"/> A contagion, copy-cat or imitation</p>
--	---	---

I7. LIFE STRESSORS Please indicate all stressors that were present for this child around the time of death.

<p>a. Life stressors - Social/economic</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Housing instability <input type="checkbox"/> Racism <input type="checkbox"/> Witnessed violence <input type="checkbox"/> Discrimination <input type="checkbox"/> Pregnancy <input type="checkbox"/> Poverty <input type="checkbox"/> Pregnancy scare <input type="checkbox"/> Neighborhood discord <input type="checkbox"/> Pregnancy <input type="checkbox"/> Job problems <input type="checkbox"/> scare <input type="checkbox"/> Money problems <input type="checkbox"/> Food insecurity</p>	<p>b. Life stressors - Relationships (age 5 and over)</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Argument with friends <input type="checkbox"/> Family discord <input type="checkbox"/> Bullying as a victim <input type="checkbox"/> Argument with parents/caregivers <input type="checkbox"/> Bullying as a perpetrator <input type="checkbox"/> Parents' divorce/separation <input type="checkbox"/> Cyberbullying as a victim <input type="checkbox"/> Parents' incarceration <input type="checkbox"/> Cyberbullying as a perpetrator <input type="checkbox"/> Argument with significant other <input type="checkbox"/> Peer violence as a victim <input type="checkbox"/> Breakup with significant other <input type="checkbox"/> Peer violence as a perpetrator <input type="checkbox"/> Social discord <input type="checkbox"/> Isolation</p>	<p>c. Life stressors - School (age 5 and over)</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> School failure <input type="checkbox"/> Pressure to succeed <input type="checkbox"/> Extracurricular activities <input type="checkbox"/> New school <input type="checkbox"/> Other school problems</p>
--	---	---

<p>d. Life stressors - Technology (age 5+)</p> <p>Stress/negative consequences due to:</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Electronic gaming <input type="checkbox"/> Texting <input type="checkbox"/> Restriction of technology <input type="checkbox"/> Social media	<p>e. Life stressors - Transitions (age 5 and over)</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Release from hospital <input type="checkbox"/> Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential, outpatient to inpatient, etc.) <input type="checkbox"/> Release from juvenile justice facility <input type="checkbox"/> End of school year/school break <input type="checkbox"/> Transition to/from child welfare system <input type="checkbox"/> Release from immigrant detention center	<p>f. Life stressors - Trauma (age 5 and over)</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Rape/sexual assault <input type="checkbox"/> Previous abuse (emotional/physical) <input type="checkbox"/> Family/domestic violence
<p>g. Life stressors - Describe any other life stressors: (age 5 and over)</p>		

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

<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> <input type="radio"/> Yes/probable <input type="radio"/> No, go to Section K <input type="radio"/> U/K, go to Section K	<p>2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>3. Did the team have information about the person(s)?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<u>One</u>	<u>Two</u>																															
<input type="radio"/>	<input type="radio"/>																															
<input type="radio"/>	<input type="radio"/>																															

<p>4. Is person listed in a previous section?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>5. Primary person(s) responsible for action(s): Select one for each person responsible.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>One</u>	<u>Two</u>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<input type="radio"/>	<input type="radio"/>																																																																												
<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																																								

<p>6. Person's age in years:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<p>7. Person's sex:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>8. Person speaks and understands English?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If no, language spoken:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>9. Person on active military duty?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, specify branch:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>One</u>	<u>Two</u>																																
_____	_____																																
<input type="checkbox"/>	<input type="checkbox"/>																																
<u>One</u>	<u>Two</u>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																
<u>One</u>	<u>Two</u>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																
<u>One</u>	<u>Two</u>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																
<input type="radio"/>	<input type="radio"/>																																

<p>10. Person(s) have history of substance abuse?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opioids <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>11. Person(s) have history of child maltreatment as victim?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> Ever in foster care or adopted	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> CPS prevention services <input type="checkbox"/> Family preservation services <input type="checkbox"/> Children ever removed	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>13. Person(s) have disability or chronic illness?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <input type="checkbox"/> Physical/orthopedic, specify: <input type="checkbox"/> Mental health/substance abuse, specify: <input type="checkbox"/> Cognitive/intellectual, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If mental health/substance abuse, was person receiving mental health services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>One</u>	<u>Two</u>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<u>One</u>	<u>Two</u>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<u>One</u>	<u>Two</u>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<u>One</u>	<u>Two</u>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		
<input type="radio"/>	<input type="radio"/>																																		

<p>14. Person(s) have prior child deaths?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>Other, specify: <input type="checkbox"/> U/K</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>15. Person(s) have history of intimate partner violence?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>16. Person(s) have delinquent/criminal history?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> <p>If yes, check all that apply:</p> <input type="checkbox"/> Assaults <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>One</u>	<u>Two</u>																																															
<input type="radio"/>	<input type="radio"/>																																															
<input type="radio"/>	<input type="radio"/>																																															
<input type="radio"/>	<input type="radio"/>																																															
<u>One</u>	<u>Two</u>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<u>One</u>	<u>Two</u>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<input type="checkbox"/>	<input type="checkbox"/>																																															
<u>One</u>	<u>Two</u>																																															
<input type="radio"/>	<input type="radio"/>																																															
<input type="radio"/>	<input type="radio"/>																																															
<input type="radio"/>	<input type="radio"/>																																															

17. At the time of the incident, was the person asleep? One Two

<u>One</u>	<u>Two</u>	If yes, select the most appropriate description of the person's sleeping period at incident:	} <u>One</u>	<u>Two</u>	
<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	Night time sleep
<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	Day time nap, describe:
<input type="radio"/>	<input type="radio"/>	U/K	<input type="radio"/>	<input type="radio"/>	Day time sleep (for example, person is night shift worker), describe:
			<input type="radio"/>	<input type="radio"/>	Other, describe:

<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 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"><u>One</u></td> <td style="width: 15%;"><u>Two</u></td> <td style="width: 15%;"><u>One</u> <u>Two</u></td> <td style="width: 15%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Drug impaired, specify:</td> <td><input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Alcohol impaired</td> <td><input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Distracted</td> <td><input type="checkbox"/> <input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Absent</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u> <u>Two</u>		<input type="checkbox"/>	<input type="checkbox"/>	Drug impaired, specify:	<input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol impaired	<input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Distracted	<input type="checkbox"/> <input type="checkbox"/> Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Absent		<p>19. Person(s) have, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions</p>	<p>20. Legal outcomes in this death, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
<u>One</u>	<u>Two</u>	<u>One</u> <u>Two</u>																				
<input type="checkbox"/>	<input type="checkbox"/>	Drug impaired, specify:	<input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:																			
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol impaired	<input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:																			
<input type="checkbox"/>	<input type="checkbox"/>	Distracted	<input type="checkbox"/> <input type="checkbox"/> Other, specify:																			
<input type="checkbox"/>	<input type="checkbox"/>	Absent																				

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 <u>before review</u>	Review led to <u>referral</u>	Referral needed, <u>not available</u>	N/A	U/K
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. FINDINGS IDENTIFIED DURING THE REVIEW Mark this case to edit/add findings at a later date

1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)

2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interacted or the response to the incident. (See Data Dictionary for examples.)

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

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

If yes, select all that apply and describe:

<input type="checkbox"/> Child welfare	Describe:	<input type="checkbox"/> Education	Describe:
<input type="checkbox"/> Law enforcement	Describe:	<input type="checkbox"/> Mental health	Describe:
<input type="checkbox"/> Public health	Describe:	<input type="checkbox"/> EMS	Describe:
<input type="checkbox"/> Coroner/medical examiner	Describe:	<input type="checkbox"/> Substance abuse	Describe:
<input type="checkbox"/> Courts	Describe:	<input type="checkbox"/> Other, specify:	Describe:
<input type="checkbox"/> Health care systems	Describe:		

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

M. THE REVIEW MEETING PROCESS

1. Date of first review meeting: _____	2. Number of review meetings for this case: _____	3. Is review complete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No
4. Agencies and individuals at review meeting, check all that apply:		
<input type="checkbox"/> Medical examiner/coroner/pathologist	<input type="checkbox"/> CPS	<input type="checkbox"/> Fire
<input type="checkbox"/> Death investigator	<input type="checkbox"/> Other social services	<input type="checkbox"/> EMS
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Physician	<input type="checkbox"/> Faith based organization
<input type="checkbox"/> Prosecutor/district attorney	<input type="checkbox"/> Nurse	<input type="checkbox"/> Education
<input type="checkbox"/> Public health	<input type="checkbox"/> Hospital	<input type="checkbox"/> Mental health
<input type="checkbox"/> HMO/managed care	<input type="checkbox"/> Other health care	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Indian Health Services/ Tribal Health	<input type="checkbox"/> Military	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Home visiting	<input type="checkbox"/> Healthy Start	<input type="checkbox"/> Others, list: _____
<input type="checkbox"/> Court	<input type="checkbox"/> Child advocate	
5. Were the following data sources available at the review meeting? Check all that apply:	6. Did any of the following factors reduce meeting effectiveness, check all that apply:	
<input type="checkbox"/> CDC's SUIDI Reporting Form	<input type="checkbox"/> None	
<input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form	<input type="checkbox"/> Confidentiality issues among members prevented full exchange of information	
<input type="checkbox"/> Birth certificate - full form	<input type="checkbox"/> HIPAA regulations prevented access to or exchange of information	
<input type="checkbox"/> Death certificate	<input type="checkbox"/> Inadequate investigation precluded having enough information for review	
<input type="checkbox"/> Child's medical records or clinical history, including vaccinations	<input type="checkbox"/> Team members did not bring adequate information to the meeting	
<input type="checkbox"/> Biological mother's obstetric and prenatal information	<input type="checkbox"/> Necessary team members were absent	
<input type="checkbox"/> Newborn screening results	<input type="checkbox"/> Meeting was held too soon after death	
<input type="checkbox"/> Law enforcement records	<input type="checkbox"/> Meeting was held too long after death	
<input type="checkbox"/> Social service records	<input type="checkbox"/> Records or information were needed from another locality in-state	
<input type="checkbox"/> Child protection agency records	<input type="checkbox"/> Records or information were needed from another state	
<input type="checkbox"/> EMS run sheet	<input type="checkbox"/> Team disagreement on circumstances	
<input type="checkbox"/> Hospital records	<input type="checkbox"/> Other factors, specify: _____	
<input type="checkbox"/> Autopsy/pathology reports		
<input type="checkbox"/> Home visiting		
<input type="checkbox"/> Mental health records		
<input type="checkbox"/> School records		
<input type="checkbox"/> Substance abuse treatment records		
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	

N. SUID AND SDY CASE REGISTRY

This section displays online based on your state's settings.

Section N: OMB No. 0920-1092, Exp. Date: 4/30/2022

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

1. Is this an SDY or SUID case? <input type="radio"/> Yes <input type="radio"/> No	If no, go to Section O
2. Did this case go to Advanced Review for the SDY Case Registry? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No If yes, date of first Advanced Review meeting: _____	3. Notes from Advanced Review meeting (include case details that helped determine SDY categorization and any ways to improve the review) or reason why case did not go to Advanced Review: _____
4. Professionals at the Advanced Review meeting, check all that apply:	
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Death investigator
<input type="checkbox"/> CDR representative	<input type="checkbox"/> Epileptologist
<input type="checkbox"/> Coroner	<input type="checkbox"/> Forensic pathologist/medical examiner
<input type="checkbox"/> Geneticist or genetic counselor	<input type="checkbox"/> Pediatrician
<input type="checkbox"/> Mental health professional	<input type="checkbox"/> Public health representative
<input type="checkbox"/> Neonatologist	<input type="checkbox"/> Others, specify: _____
5. Did the Advanced Review team believe the autopsy was comprehensive? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

<p>7. Was a specimen saved for the SDY Case Registry? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>9. Did the family consent to have DNA saved as part of the SDY Case Registry? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, why not? <input type="radio"/> Consent was not attempted <input type="radio"/> Consent was attempted but follow up was unsuccessful <input type="radio"/> Consent was attempted but family declined <input type="radio"/> Other, specify:</p>
<p>8. Was a specimen sent to the SDY Case Registry biorepository? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	

10. Categorization for SDY Case Registry (choose only one):

<input type="radio"/> Excluded from SDY Case Registry	<input type="radio"/> Explained neurological, specify:	<input type="radio"/> Explained other, specify:	<input type="radio"/> Unexplained, SUDEP
<input type="radio"/> Incomplete case information	<input type="radio"/> Explained infant suffocation (under age 1)	<input type="radio"/> Unexplained, possible cardiac	<input type="radio"/> Unexplained death
<input type="radio"/> Explained cardiac, specify:		<input type="radio"/> Unexplained, possible cardiac and SUDEP	

11. Categorization for SUID Case Registry (choose only one):

<input type="radio"/> Excluded (other explained causes, not suffocation) <input type="radio"/> Unexplained: No autopsy or death scene investigation <input type="radio"/> Unexplained: Incomplete case information <input type="radio"/> Unexplained: No unsafe sleep factors <input type="radio"/> Unexplained: Unsafe sleep factors <input type="radio"/> Unexplained: Possible suffocation with unsafe sleep factors <input type="radio"/> Explained: Suffocation with unsafe sleep factors	If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply: <input type="checkbox"/> Soft bedding <input type="checkbox"/> Wedging <input type="checkbox"/> Overlay <input type="checkbox"/> Other, specify:
--	--

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.

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"/>			



The development of this report tool was supported, in part, by Grant No. UG7MC28482 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services and with additional funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health
 Data Entry: <https://data.ncfrp.org>
www.ncfrp.org info@ncfrp.org 1-800-656-2434 Facebook and Twitter: NationalCFRP