



**CDR Report Form**  
***National Fatality Review***  
***Case Reporting System***

Version 5.0



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

1-800-656-2434

[info@ncfrp.org](mailto:info@ncfrp.org)

[www.ncfrp.org](http://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.

## HIPAA Reminder:

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

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



<p>29. Child's mental health (MH):</p> <p>Child had received prior MH services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Child was receiving MH services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Child on medications for MH illness?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Issues prevented child from receiving MH services?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>30. Child had history of substance 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> <p><input type="checkbox"/> Alcohol <input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter drugs</p>	<p>31. 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> <p><input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs <input type="checkbox"/> U/K</p>
		<p>32. 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>33. Child acutely ill in the two weeks before death?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>

**A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR**

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

<p>35. Gestational age: <input type="checkbox"/> U/K</p> <p>_____ # weeks</p>	<p>36. Birth weight: <input type="checkbox"/> U/K</p> <p><input type="radio"/> Grams/kilograms _____</p> <p><input type="radio"/> Pounds/ounces _____</p>	<p>37. Multiple gestation?  <input type="radio"/> Yes, # _____</p> <p><input type="radio"/> No <input type="radio"/> U/K</p>	<p>38. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K</p>	<p>39. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K</p>
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<p>40. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K</p>	<p>41. 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>
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42. 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	

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

<p><input checked="" type="checkbox"/> <b>Cardiovascular</b></p> <p><input type="checkbox"/> Hypertension - gestational</p> <p><input type="checkbox"/> Hypertension - chronic</p> <p><input type="checkbox"/> Pre-eclampsia</p> <p><input type="checkbox"/> Eclampsia</p> <p><input type="checkbox"/> Clotting disorder</p> <p><input checked="" type="checkbox"/> <b>Hematologic</b></p> <p><input type="checkbox"/> Folic acid deficiency</p> <p><input type="checkbox"/> Sickle cell disease</p> <p><input type="checkbox"/> Anemia (iron deficiency)</p> <p><input checked="" type="checkbox"/> <b>Respiratory</b></p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Pulmonary embolism</p>	<p><input checked="" type="checkbox"/> <b>Endocrine/Metabolic</b></p> <p><input type="checkbox"/> Diabetes, type 1 chronic</p> <p><input type="checkbox"/> Diabetes, type 2 chronic</p> <p><input type="checkbox"/> Diabetes, gestational</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Polycystic ovarian disease</p> <p><input checked="" type="checkbox"/> <b>Neurologic/Psychiatric</b></p> <p><input type="checkbox"/> Addiction disorder</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Seizure disorder</p> <p><input checked="" type="checkbox"/> <b>Sexually Transmitted Infection (STI)</b></p> <p><input type="checkbox"/> Bacterial vaginosis (BV)</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> HPV</p> <p><input type="checkbox"/> Syphilis</p>	<p><input checked="" type="checkbox"/> <b>STI (continued)</b></p> <p><input type="checkbox"/> Group B strep</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Other STI, specify: _____</p> <p><input checked="" type="checkbox"/> <b>Gynecologic</b></p> <p><input type="checkbox"/> Uterine/vaginal bleeding</p> <p><input type="checkbox"/> Chorioamnionitis</p> <p><input type="checkbox"/> Oligohydramnios</p> <p><input type="checkbox"/> Polyhydramnios</p> <p><input type="checkbox"/> Intrauterine growth restriction (IUGR)</p> <p><input type="checkbox"/> Premature rupture of membranes (PROM)</p> <p><input type="checkbox"/> Preterm premature rupture of membranes (PPROM)</p> <p><input type="checkbox"/> Incompetent cervix</p> <p><input checked="" type="checkbox"/> <b>Umbilical cord complications</b></p> <p><input type="checkbox"/> Prolapse</p> <p><input type="checkbox"/> Nuchal cord</p> <p><input type="checkbox"/> Other cord, specify: _____</p>	<p><input checked="" type="checkbox"/> <b>Gynecologic (continued)</b></p> <p><input checked="" type="checkbox"/> Placental problems</p> <p><input type="checkbox"/> Abruptio</p> <p><input type="checkbox"/> Previa</p> <p><input type="checkbox"/> Other placental, specify: _____</p> <p><input checked="" type="checkbox"/> <b>Other Condition/Complication</b></p> <p><input type="checkbox"/> UTI</p> <p><input type="checkbox"/> Decreased fetal movement</p> <p><input type="checkbox"/> HELLP syndrome</p> <p><input type="checkbox"/> Maternal developmental delay</p> <p><input type="checkbox"/> Oral health/dental or gum infection</p> <p><input type="checkbox"/> Gastrointestinal</p> <p><input type="checkbox"/> Maternal genetic disorder</p> <p><input type="checkbox"/> Abnormal MSAFP</p> <p><input type="checkbox"/> Preterm labor</p> <p><input type="checkbox"/> Other, specify: _____</p>
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44. Did the mother experience any medical complications in previous pregnancies?  N/A  Yes  No  U/K If yes, check all that apply:

<input type="checkbox"/> Previous preterm birth	<input type="checkbox"/> Previous small for gestational age
<input type="checkbox"/> Previous low birth weight birth	<input type="checkbox"/> Previous large for gestational age (greater than 4000 grams)

45. Did the mother use any medications, drugs or other substances during pregnancy?  Yes  No  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"/> Opiates
<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:

46. Was the infant born drug exposed?  Yes  No  U/K

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

<p>48. Level of birth hospital:</p> <p><input type="radio"/> 1°</p> <p><input type="radio"/> 2°</p> <p><input type="radio"/> 3°</p> <p><input type="radio"/> Free-standing birth hospital</p> <p><input type="radio"/> Home birth</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>49. At discharge from the birth hospital, was a case manager assigned to the mother?</p> <p><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</p>																		
	<p>50. Did the mother attend a postpartum visit?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>																		
	<p>51. Did the infant have a NICU stay of more than one day?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, for what reason(s)? Check all that apply:</p> <p><input type="checkbox"/> Prematurity    <input type="checkbox"/> Apnea    <input type="checkbox"/> Hypothermia    <input type="checkbox"/> Meconium aspiration</p> <p><input type="checkbox"/> Low birth weight    <input type="checkbox"/> Sepsis    <input type="checkbox"/> Jaundice    <input type="checkbox"/> Congenital anomalies</p> <p><input type="checkbox"/> Tachypnea    <input type="checkbox"/> Feeding difficulties    <input type="checkbox"/> Anemia    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Drug/alcohol exposure    <input type="checkbox"/> U/K</p>																		
<p>52. Did mother smoke in the 3 months before pregnancy?</p> <p><input type="radio"/> Yes    If yes, ___ Avg # cigarettes/day</p> <p><input type="radio"/> No    (20 cigarettes in pack)</p> <p><input type="radio"/> U/K    <input type="checkbox"/> U/K quantity</p>	<p>53. Did the mother smoke at any time during pregnancy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;"><u>Trimester 1</u></td> <td style="text-align: center;"><u>Trimester 2</u></td> <td style="text-align: center;"><u>Trimester 3</u></td> <td></td> </tr> <tr> <td colspan="3">If yes, _____</td> <td style="text-align: right;">Avg # cigarettes/day</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">(20 cigarettes in pack)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: right;">U/K quantity</td> </tr> </table>			<u>Trimester 1</u>	<u>Trimester 2</u>	<u>Trimester 3</u>		If yes, _____			Avg # cigarettes/day				(20 cigarettes in pack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K quantity
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If yes, _____			Avg # cigarettes/day																
			(20 cigarettes in pack)																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K quantity																
<p>54. Was mother injured during pregnancy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, describe:</p>		<p>55. Did the mother have postpartum depression?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>																	
<p>If this was a fetal death, go to Section B.</p>																			
<p>56. Infant ever breastfed?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>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</p> <p>    If yes, exclusively?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>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</p> <p>    If yes, exclusively?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If ever, was infant receiving breast milk at time of death?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>		<p>57. Did infant have abnormal metabolic newborn screening results?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, describe any abnormality such as a fatty acid oxidation error:</p>																	
<p>If the infant never left the hospital following birth, go to Section B.</p>																			
<p>58. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):</p> <p><input type="checkbox"/> None    <input type="checkbox"/> Cyanosis</p> <p><input type="checkbox"/> Infection    <input type="checkbox"/> Seizures or convulsions</p> <p><input type="checkbox"/> Allergies    <input type="checkbox"/> Cardiac abnormalities</p> <p><input type="checkbox"/> Abnormal growth, weight gain/loss    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Apnea    <input type="checkbox"/> U/K</p>		<p>59. In the 72 hours prior to death, did the infant have any of the following? Check all that apply:</p> <p><input type="checkbox"/> None    <input type="checkbox"/> Vomiting    <input type="checkbox"/> Cyanosis</p> <p><input type="checkbox"/> Fever    <input type="checkbox"/> Choking    <input type="checkbox"/> Seizures or convulsions</p> <p><input type="checkbox"/> Excessive sweating    <input type="checkbox"/> Diarrhea    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Lethargy/sleeping more than usual    <input type="checkbox"/> Stool changes</p> <p><input type="checkbox"/> Fussiness/excessive crying    <input type="checkbox"/> Difficulty breathing    <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Decrease in appetite    <input type="checkbox"/> Apnea</p>																	
<p>60. In the 72 hours prior to death, was the infant injured?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, describe cause and injuries:</p>	<p>61. In the 72 hours prior to death, was the infant given any vaccines?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, list name(s) of vaccines:</p>	<p>62. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies.</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, list name and last dose given:</p>	<p>63. What did the infant have for his/her last meal? Check all that apply:</p> <p><input type="checkbox"/> Breast milk</p> <p><input type="checkbox"/> Formula, type:</p> <p><input type="checkbox"/> Baby food, type:</p> <p><input type="checkbox"/> Cereal, type:</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>																
<p>This space left intentionally blank.</p>																			

**B. BIOLOGICAL PARENT INFORMATION**

No information available, go to Section C

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

15. Parents have prior child deaths?

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

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

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

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

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

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

One	Two	One	Two	One	Two
<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

2. Caregiver(s) age in years:

One	Two
_____	_____
# Years	
<input type="checkbox"/>	<input type="checkbox"/>
U/K	

3. Caregiver(s) sex:

One	Two
<input type="radio"/>	Male
<input type="radio"/>	Female
<input type="radio"/>	U/K

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

One	Two	One	Two
<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"/>	Alaskan Native, Tribe:	<input type="checkbox"/>	

5. Caregiver(s) Hispanic or Latino origin?

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

If yes, specify origin:

6. Caregiver(s) employment status:

One	Two
<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

7. Caregiver(s) income:

One	Two
<input type="radio"/>	High
<input type="radio"/>	Medium
<input type="radio"/>	Low
<input type="radio"/>	U/K

8. Caregiver(s) education:

One	Two
<input type="radio"/>	< High school
<input type="radio"/>	High school
<input type="radio"/>	College
<input type="radio"/>	Post graduate
<input type="radio"/>	U/K

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

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

If no, language spoken:

10. Caregiver(s) first generation immigrant?

One	Two
<input type="radio"/>	Yes, country of origin:
<input type="radio"/>	No
<input type="radio"/>	U/K

11. Caregiver(s) on active military duty?

One	Two
<input type="radio"/>	Yes, specify branch:
<input type="radio"/>	No
<input type="radio"/>	U/K

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

One	Two	One	Two
<input type="radio"/>	Yes	<input type="checkbox"/>	WIC
<input type="radio"/>	No	<input type="checkbox"/>	Home visiting, specify:
<input type="radio"/>	U/K	<input type="checkbox"/>	TANF
If yes, check all that apply:		<input type="checkbox"/>	Medicaid
		<input type="checkbox"/>	Food stamps/SNAP/EBT
		<input type="checkbox"/>	Other, specify:
		<input type="checkbox"/>	U/K

13. Caregiver(s) have substance abuse history?

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

If yes, check all that apply:

<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Cocaine
<input type="checkbox"/>	Marijuana
<input type="checkbox"/>	Methamphetamine
<input type="checkbox"/>	Opiates
<input type="checkbox"/>	Prescription drugs
<input type="checkbox"/>	Over-the-counter
<input type="checkbox"/>	Other, specify:
<input type="checkbox"/>	U/K

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

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

If yes, check all that apply:

<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

Ever in foster care or adopted

15. Caregiver(s) ever perpetrator of maltreatment?

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

If yes, check all that apply:

<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

CPS prevention services

Family preservation services

Children ever removed

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

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

If yes, check all that apply:

<input type="checkbox"/>	Physical/orthopedic, specify:
<input type="checkbox"/>	Mental health/substance abuse, specify:
<input type="checkbox"/>	Cognitive/intellectual, specify:
<input type="checkbox"/>	Sensory, specify:
<input type="checkbox"/>	U/K

If mental health/substance abuse, was caregiver receiving MH services?

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

17. Caregiver(s) have prior child deaths?

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

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

One	Two
<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

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

One	Two
<input type="checkbox"/>	Yes, as victim
<input type="checkbox"/>	Yes, as perpetrator
<input type="checkbox"/>	No
<input type="checkbox"/>	U/K

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

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

If yes, check all that apply:

<input type="checkbox"/>	Assaults
<input type="checkbox"/>	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"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care/adopted</p> <p><input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> Children ever removed</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical/orthopedic, specify:</p> <p><input type="checkbox"/> Mental health/substance abuse, specify:</p> <p><input type="checkbox"/> Cognitive/intellectual, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental health/substance abuse, was supervisor receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Undetermined cause # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>

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

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

<p>1. Was the date of the incident the same as the date of death?</p> <p><input type="radio"/> Yes, same as date of death</p> <p><input type="radio"/> No, different than date of death. Enter date of incident: _____ / _____ / _____</p> <p><input type="radio"/> U/K</p>	<p>2. Approximate time of day that incident occurred?</p> <p><input type="radio"/> AM</p> <p>Hour, specify 1-12 _____ <input type="radio"/> PM</p> <p><input type="radio"/> U/K</p>
<p>3. Place of incident, check all that apply:</p> <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:	7. Did the death occur due to a natural disaster or mass fatality? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:	8. Was the incident witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> UK If yes, by whom? <input type="checkbox"/> Parent/relative <input type="checkbox"/> Health care professional, if death occurred in a hospital setting <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Stranger <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Other, specify:
6. Incident county:		
9. Was 911 or local emergency called? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
10. Was resuscitation attempted? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
If yes, by whom? <input type="checkbox"/> EMS <input type="checkbox"/> Stranger <input type="checkbox"/> Parent/relative <input type="checkbox"/> Other, specify: <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Health care professional, if death occurred in a hospital setting	If yes, type of resuscitation: <input type="checkbox"/> CPR <input type="checkbox"/> Automated External Defibrillator (AED) If no AED, was AED available/accessible? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If AED, was shock administered? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many shocks were administered? _____ <input type="checkbox"/> Rescue medications, specify type: <input type="checkbox"/> Other, specify:	If yes, was a rhythm recorded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  If yes, what was the rhythm? _____
11. At time of incident leading to death, had child used drugs or alcohol? If yes, check all that apply: <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Alcohol <input type="checkbox"/> Opiate <input type="checkbox"/> U/K <input type="checkbox"/> Cocaine <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Marijuana <input type="checkbox"/> Over-the-counter drugs <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify:		12. Child's activity at time of incident, check all that apply: <input type="checkbox"/> Sleeping <input type="checkbox"/> Working <input type="checkbox"/> Driving/vehicle occupant <input type="checkbox"/> U/K <input type="checkbox"/> Playing <input type="checkbox"/> Eating <input type="checkbox"/> Other, specify:  13. Total number of deaths at incident event, including child: _____ Children, ages 0-18 <input type="radio"/> U/K _____ Adults

**F. INVESTIGATION INFORMATION**

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

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

**G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH**

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

5. Official manner of death from the death certificate:  <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K	6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.  <table style="width:100%;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u>  <input type="radio"/> Motor vehicle and other transport, go to H1  <input type="radio"/> Fire, burn, or electrocution, go to H2  <input type="radio"/> Drowning, go to H3  <input type="radio"/> Unintentional asphyxia, go to H4  <input type="radio"/> Assault, weapon or person's body part, go to H5  <input type="radio"/> Fall or crush, go to H6  <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7  <input type="radio"/> Undetermined injury, go to I1  <input type="radio"/> Other cause, go to H9  <input type="radio"/> U/K, go to I1         </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From a medical cause. Select one:</u>  <input type="radio"/> Asthma/respiratory, specify and go to H8  <input type="radio"/> Cancer, specify and go to H8  <input type="radio"/> Cardiovascular, specify and go to H8  <input type="radio"/> Congenital anomaly, specify and go to H8  <input type="radio"/> Diabetes, go to H8  <input type="radio"/> HIV/AIDS, go to H8  <input type="radio"/> Influenza, go to H8  <input type="radio"/> Low birth weight, go to H8  <input type="radio"/> Malnutrition/dehydration, go to H8  <input type="radio"/> Neurological/seizure disorder, go to H8  <input type="radio"/> Pneumonia, specify and go to H8  <input type="radio"/> Prematurity, go to H8  <input type="radio"/> SIDS, go to H8  <input type="radio"/> Other infection, specify and go to H8  <input type="radio"/> Other perinatal condition, specify and go to H8  <input type="radio"/> Other medical condition, specify and go to H8  <input type="radio"/> Undetermined medical cause, go to H8  <input type="radio"/> U/K, go to H8         </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>Undetermined if injury or medical cause, go to I1</u>      <input type="radio"/> <u>U/K go to I1</u> </td> </tr> </table>	<input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u> <input type="radio"/> Motor vehicle and other transport, go to H1 <input type="radio"/> Fire, burn, or electrocution, go to H2 <input type="radio"/> Drowning, go to H3 <input type="radio"/> Unintentional asphyxia, go to H4 <input type="radio"/> Assault, weapon or person's body part, go to H5 <input type="radio"/> Fall or crush, go to H6 <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 <input type="radio"/> Undetermined injury, go to I1 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I1	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma/respiratory, specify and go to H8 <input type="radio"/> Cancer, specify and go to H8 <input type="radio"/> Cardiovascular, specify and go to H8 <input type="radio"/> Congenital anomaly, specify and go to H8 <input type="radio"/> Diabetes, go to H8 <input type="radio"/> HIV/AIDS, go to H8 <input type="radio"/> Influenza, go to H8 <input type="radio"/> Low birth weight, go to H8 <input type="radio"/> Malnutrition/dehydration, go to H8 <input type="radio"/> Neurological/seizure disorder, go to H8 <input type="radio"/> Pneumonia, specify and go to H8 <input type="radio"/> Prematurity, go to H8 <input type="radio"/> SIDS, go to H8 <input type="radio"/> Other infection, specify and go to H8 <input type="radio"/> Other perinatal condition, specify and go to H8 <input type="radio"/> Other medical condition, specify and go to H8 <input type="radio"/> Undetermined medical cause, go to H8 <input type="radio"/> U/K, go to H8	<input type="radio"/> <u>Undetermined if injury or medical cause, go to I1</u> <input type="radio"/> <u>U/K go to I1</u>
<input type="radio"/> <u>From an injury (external cause). Select one and answer G4:</u> <input type="radio"/> Motor vehicle and other transport, go to H1 <input type="radio"/> Fire, burn, or electrocution, go to H2 <input type="radio"/> Drowning, go to H3 <input type="radio"/> Unintentional asphyxia, go to H4 <input type="radio"/> Assault, weapon or person's body part, go to H5 <input type="radio"/> Fall or crush, go to H6 <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 <input type="radio"/> Undetermined injury, go to I1 <input type="radio"/> Other cause, go to H9 <input type="radio"/> U/K, go to I1	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma/respiratory, specify and go to H8 <input type="radio"/> Cancer, specify and go to H8 <input type="radio"/> Cardiovascular, specify and go to H8 <input type="radio"/> Congenital anomaly, specify and go to H8 <input type="radio"/> Diabetes, go to H8 <input type="radio"/> HIV/AIDS, go to H8 <input type="radio"/> Influenza, go to H8 <input type="radio"/> Low birth weight, go to H8 <input type="radio"/> Malnutrition/dehydration, go to H8 <input type="radio"/> Neurological/seizure disorder, go to H8 <input type="radio"/> Pneumonia, specify and go to H8 <input type="radio"/> Prematurity, go to H8 <input type="radio"/> SIDS, go to H8 <input type="radio"/> Other infection, specify and go to H8 <input type="radio"/> Other perinatal condition, specify and go to H8 <input type="radio"/> Other medical condition, specify and go to H8 <input type="radio"/> Undetermined medical cause, go to H8 <input type="radio"/> U/K, go to H8	<input type="radio"/> <u>Undetermined if injury or medical cause, go to I1</u> <input type="radio"/> <u>U/K go to I1</u>		

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

**H1. MOTOR VEHICLE AND OTHER TRANSPORT**

<p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Child's</th> <th style="text-align: left; border-bottom: 1px solid black;">Other primary vehicle</th> </tr> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> None</td> </tr> <tr> <td><input type="radio"/> Car</td> <td><input type="radio"/> Car</td> </tr> <tr> <td><input type="radio"/> Van</td> <td><input type="radio"/> Van</td> </tr> <tr> <td><input type="radio"/> Sport utility vehicle</td> <td><input type="radio"/> Sport utility vehicle</td> </tr> <tr> <td><input type="radio"/> Truck</td> <td><input type="radio"/> Truck</td> </tr> <tr> <td><input type="radio"/> Semi/tractor trailer</td> <td><input type="radio"/> Semi/tractor trailer</td> </tr> <tr> <td><input type="radio"/> RV</td> <td><input type="radio"/> RV</td> </tr> <tr> <td><input type="radio"/> School bus</td> <td><input type="radio"/> School bus</td> </tr> <tr> <td><input type="radio"/> Other bus</td> <td><input type="radio"/> Other bus</td> </tr> <tr> <td><input type="radio"/> Motorcycle</td> <td><input type="radio"/> Motorcycle</td> </tr> <tr> <td><input type="radio"/> Tractor</td> <td><input type="radio"/> Tractor</td> </tr> <tr> <td><input type="radio"/> Other farm vehicle</td> <td><input type="radio"/> Other farm vehicle</td> </tr> <tr> <td><input type="radio"/> All terrain vehicle</td> <td><input type="radio"/> All terrain vehicle</td> </tr> <tr> <td><input type="radio"/> Snowmobile</td> <td><input type="radio"/> Snowmobile</td> </tr> <tr> <td><input type="radio"/> Bicycle</td> <td><input type="radio"/> Bicycle</td> </tr> <tr> <td><input type="radio"/> Train</td> <td><input type="radio"/> Train</td> </tr> <tr> <td><input type="radio"/> Subway</td> <td><input type="radio"/> Subway</td> </tr> <tr> <td><input type="radio"/> Trolley</td> <td><input type="radio"/> Trolley</td> </tr> <tr> <td><input type="radio"/> Other, specify:</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>	Child's	Other primary vehicle	<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> Car	<input type="radio"/> Car	<input type="radio"/> Van	<input type="radio"/> Van	<input type="radio"/> Sport utility vehicle	<input type="radio"/> Sport utility vehicle	<input type="radio"/> Truck	<input type="radio"/> Truck	<input type="radio"/> Semi/tractor trailer	<input type="radio"/> Semi/tractor trailer	<input type="radio"/> RV	<input type="radio"/> RV	<input type="radio"/> School bus	<input type="radio"/> School bus	<input type="radio"/> Other bus	<input type="radio"/> Other bus	<input type="radio"/> Motorcycle	<input type="radio"/> Motorcycle	<input type="radio"/> Tractor	<input type="radio"/> Tractor	<input type="radio"/> Other farm vehicle	<input type="radio"/> Other farm vehicle	<input type="radio"/> All terrain vehicle	<input type="radio"/> All terrain vehicle	<input type="radio"/> Snowmobile	<input type="radio"/> Snowmobile	<input type="radio"/> Bicycle	<input type="radio"/> Bicycle	<input type="radio"/> Train	<input type="radio"/> Train	<input type="radio"/> Subway	<input type="radio"/> Subway	<input type="radio"/> Trolley	<input type="radio"/> Trolley	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>b. Position of child:</p> <p><input type="radio"/> Driver</p> <p><input type="radio"/> Passenger      If passenger, relationship of driver to child:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="radio"/> Front seat</td> <td><input type="radio"/> Biological parent</td> </tr> <tr> <td><input type="radio"/> Back seat</td> <td><input type="radio"/> Adoptive parent</td> </tr> <tr> <td><input type="radio"/> Truck bed</td> <td><input type="radio"/> Stepparent</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Foster parent</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Mother's partner</td> </tr> <tr> <td><input type="radio"/> On bicycle</td> <td><input type="radio"/> Father's partner</td> </tr> <tr> <td><input type="radio"/> Pedestrian</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Walking</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Boarding/blading</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<input type="radio"/> Front seat	<input type="radio"/> Biological parent	<input type="radio"/> Back seat	<input type="radio"/> Adoptive parent	<input type="radio"/> Truck bed	<input type="radio"/> Stepparent	<input type="radio"/> Other, specify:	<input type="radio"/> Foster parent	<input type="radio"/> U/K	<input type="radio"/> Mother's partner	<input type="radio"/> On bicycle	<input type="radio"/> Father's partner	<input type="radio"/> Pedestrian	<input type="radio"/> Grandparent	<input type="radio"/> Walking	<input type="radio"/> Sibling	<input type="radio"/> Boarding/blading	<input type="radio"/> Other relative	<input type="radio"/> Other, specify:	<input type="radio"/> Friend	<input type="radio"/> U/K	<input type="radio"/> Other, specify:	<input type="radio"/> U/K	<input type="radio"/> U/K	<p>c. Causes of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Back/front over</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Flipover</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Ran stop sign or red light</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Driver distraction</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Driver inexperience</td> <td><input type="checkbox"/> Animal in road</td> </tr> <tr> <td><input type="checkbox"/> Mechanical failure</td> <td><input type="checkbox"/> Cell phone use while driving</td> </tr> <tr> <td><input type="checkbox"/> Poor tires</td> <td><input type="checkbox"/> Racing, not authorized</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Drugs or alcohol use</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/sleeping</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical event, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Back/front over	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Flipover	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Animal in road	<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Cell phone use while driving	<input type="checkbox"/> Poor tires	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Poor weather	<input type="checkbox"/> Other driver error, specify:	<input type="checkbox"/> Poor visibility	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Drugs or alcohol use	<input type="checkbox"/> U/K	<input type="checkbox"/> Fatigue/sleeping		<input type="checkbox"/> Medical event, specify:	
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g. Drivers involved in incident, check all that apply:

Child as driver	Child's driver	Driver of other primary vehicle	Child as driver	Child's driver	Driver of other primary vehicle
Age of Driver	Age of Driver		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a graduated license
<input type="radio"/>	<input type="radio"/> <16 years		<input type="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"/> Responsible for causing incident		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Passenger restrictions
<input type="checkbox"/>	<input type="checkbox"/> Was alcohol/drug impaired		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Driving without required supervision
<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"/> Has a learner's permit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K

h. Total number of occupants in vehicles:

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

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

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

## H2. FIRE, BURN, OR ELECTROCUTION

<b>a. Ignition, heat or electrocution source:</b> <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>b. Type of incident:</b> <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		<b>c. For fire, child died from:</b> <input type="radio"/> Burns <input type="radio"/> Smoke inhalation <input type="radio"/> Other, specify:  <input type="radio"/> U/K																		
<b>d. Material first ignited:</b> <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		<b>e. Type of building on fire:</b> <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		<b>f. Building's primary construction material:</b> <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		<b>g. Fire started by a person?</b> <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		<b>h. Did anyone attempt to put out fire?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <b>i. Did escape or rescue efforts worsen fire?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <b>j. Did any factors delay fire department arrival?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:																
<b>k. Were barriers preventing safe exit?</b> <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		<b>l. Was building a rental property?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K  <b>o. Was sprinkler system present?</b> <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		<b>m. Were building/rental codes violated?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe in narrative.		<b>n. Were proper working fire extinguishers present?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<b>p. Were smoke detectors present?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what type?      If yes, functioning properly?      If not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 2px;"> <input type="checkbox"/> Removable batteries  <input type="checkbox"/> Non-removable batteries  <input type="checkbox"/> Hardwired  <input type="checkbox"/> U/K                 </td> <td style="width: 33%; border-right: 1px solid black; padding: 2px;"> <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K                 </td> <td style="width: 33%; padding: 2px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Missing batteries</td> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Other</td> <td style="padding: 2px;">U/K</td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table>                 Other, specify: _____             </td> </tr> </table> If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Missing batteries</td> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Other</td> <td style="padding: 2px;">U/K</td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Missing batteries</td> <td style="width: 33%; border-right: 1px solid black; padding: 2px;">Other</td> <td style="padding: 2px;">U/K</td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="border-right: 1px solid black; text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Missing batteries	Other	U/K																						
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
<b>q. Suspected arson?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<b>r. For scald, was hot water heater set too high?</b> <input type="radio"/> N/A <input type="radio"/> Yes, temp. setting: _____ <input type="radio"/> No <input type="radio"/> U/K		<b>s. For electrocution, what cause:</b> <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		<b>t. Other, describe in detail:</b>																		

## H3. DROWNING

<b>a. Where was child last seen before drowning? Check all that apply:</b> <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>b. What was child last seen doing before drowning?</b> <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		<b>c. Was child forcibly submerged?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<b>d. Drowning location:</b> <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	
<b>e. For open water, place:</b> <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		<b>f. For open water, contributing environmental factors:</b> <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		<b>g. If boating, type of boat:</b> <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		<b>h. For boating, was the child piloting boat?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<b>i. For pool, type of pool:</b> <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		<b>j. For pool, child found:</b> <input type="radio"/> In the pool/hot tub/spa <input type="radio"/> On or under the cover <input type="radio"/> U/K		<b>k. For pool, ownership is:</b> <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K		<b>l. Length of time owners had pool/hot tub/spa:</b> <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><b>H4. UNINTENTIONAL ASPHYXIA</b></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"/> Magazine disconnect <input type="checkbox"/> Personalization device <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Other, specify: <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> U/K
		e. Where was firearm stored? <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K	
			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
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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 border="0"> <tr> <td><u>Fatal and/or Other weapon</u></td> <td><u>Fatal and/or Other weapon</u></td> </tr> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	<u>Fatal and/or Other weapon</u>	<u>Fatal and/or Other weapon</u>	<input type="checkbox"/> Self	<input type="checkbox"/> Friend	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger	<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	p. 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>	<u>Fatal and/or Other weapon</u>																											
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<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer																											
<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																											

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

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

**H6. FALL OR CRUSH**

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: <input type="radio"/> Open window <input type="radio"/> Screen <input type="radio"/> No screen <input type="radio"/> U/K if 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
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<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Grass <input type="radio"/> Gravel <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> Linoleum/vinyl <input type="radio"/> Marble/tile <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Barrier in place:</p> <p>Check all that apply:</p> <input type="checkbox"/> None <input type="checkbox"/> Screen <input type="checkbox"/> Other window guard <input type="checkbox"/> Fence <input type="checkbox"/> Railing <input type="checkbox"/> Stairway <input type="checkbox"/> Gate <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Child in a baby walker?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>h. For crush, did child:</p> <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Television <input type="radio"/> Furniture <input type="radio"/> Walls <input type="radio"/> Playground equipment <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> Boulders/rocks	<input type="radio"/> Dirt/sand <input type="radio"/> Person, go to H5q <input type="radio"/> Commercial equipment <input type="radio"/> Farm equipment <input type="radio"/> Other, specify: <input type="radio"/> U/K
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**H7. POISONING, OVERDOSE OR ACUTE INTOXICATION**

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

<u>Prescription drug</u>	<u>Over-the-counter drug</u>	<u>Illicit drugs</u>	<u>Other substances</u>
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Pain medication	<input type="checkbox"/> Pain medication (opiate)	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Pain medication (opiate)	<input type="checkbox"/> Cold medicine	<input type="checkbox"/> Pain medication (non-opiate)	<input type="checkbox"/> Carbon monoxide, go to e
<input type="checkbox"/> Pain medication (non-opiate)	<input type="checkbox"/> Other OTC, specify:	<input type="checkbox"/> Methadone	<input type="checkbox"/> Other fume/gas/vapor
<input type="checkbox"/> Methadone		<input type="checkbox"/> Cocaine	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Other Rx, specify:		<input type="checkbox"/> Heroin	
If prescription, was it child's? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

<p>b. Where was the substance stored?</p> <input type="radio"/> Open area <input type="radio"/> Open cabinet <input type="radio"/> Closed cabinet, unlocked <input type="radio"/> Closed cabinet, locked <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Was the product in its original container?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>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 detector present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many? _____ Functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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**H8. MEDICAL CONDITION**

<p>a. How long did the child have the medical condition?</p> <input type="radio"/> In utero <input type="radio"/> Weeks <input type="radio"/> Since birth <input type="radio"/> Months <input type="radio"/> Hours <input type="radio"/> Years <input type="radio"/> Days <input type="radio"/> U/K	<p>b. Was death expected as a result of the medical condition?</p> <input type="radio"/> N/A, not previously diagnosed <input type="radio"/> Yes <input type="checkbox"/> But at a later date <input type="radio"/> No <input type="radio"/> U/K	<p>c. Was child receiving health care for the medical condition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 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="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, what wasn't compliant? Check all that apply:	<input type="checkbox"/> Appointments <input type="checkbox"/> Medications, specify: <input type="checkbox"/> Medical equipment use, specify:	<input type="checkbox"/> Therapies, specify: <input type="checkbox"/> Other, specify: <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> <p>If yes, check all that apply:</p> <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Lack of transportation <input type="checkbox"/> No phone <input type="checkbox"/> Cultural differences <input type="checkbox"/> Language barriers	<input type="checkbox"/> Couldn't get provider to take as patient <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Couldn't get an earlier appointment <input type="checkbox"/> Lack of child care <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Services not available	<input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> 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: <input type="checkbox"/> U/K	<p>i. Was death caused by a medical misadventure?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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**H9. OTHER KNOWN INJURY CAUSE**

Specify cause, describe in detail:



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

**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: 12/31/2018

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
  - Unknown, 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
<b>Cardiac</b>							
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness/lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heat exhaustion/heat stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle aches/cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Neurologic</b>				Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>		
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Head injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Psychiatric symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Paralysis (acute)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>Respiratory</b>							
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

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

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

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

Yes  No  U/K

If yes, describe:

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

Condition	Diagnosed			Condition	Diagnosed			Condition	Diagnosed		
	Yes	No	U/K		Yes	No	U/K		Yes	No	U/K
<b>Blood disease</b>				<b>Neurologic</b>				<b>Other</b>			
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/ head injury/concussion	<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"/>	Brain tumor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Endocrine disorder, other: thyroid, adrenal, pituitary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Cardiac</b>				Brain aneurysm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hearing problems or deafness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal electrocardiogram (EKG or ECG)	<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"/>
Aneurysm or aortic dilatation	<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"/>
Arrhythmia/arrhythmia syndrome	<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"/>
Cardiomyopathy	<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"/>
Commotio cordis	<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"/>
Congenital heart disease	<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 abnormality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke/mini stroke/ TIA-Transient Ischemic Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital disorder/ genetic syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery disease (atherosclerosis)	<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"/>	Other, specify:	<input type="radio"/>		
Endocarditis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>Respiratory</b>							
Heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary embolism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary hemorrhage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Myocarditis (heart infection)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Pulmonary hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								
Sudden cardiac arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								





<b>Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)</b>																
<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</p> <p><input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure)</p> <p><input type="checkbox"/> Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)</p> <p><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="border: none;"><input type="checkbox"/> Brain injury/trauma, specify:</td> <td style="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</p> <p><input type="checkbox"/> Last more than 30 minutes (status epilepticus)</p> <p><input type="checkbox"/> Occur in the presence of fever (febrile seizure)</p> <p><input type="checkbox"/> Occur in the absence of fever</p> <p><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"/> 4   <input type="radio"/> More than 6 <input type="radio"/> 2   <input type="radio"/> 5   <input type="radio"/> U/K <input type="radio"/> 3   <input type="radio"/> 6</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="border: none;"><input type="radio"/> Crib</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;">If adult bed, what type?</td> <td style="border: none;">If futon,</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> <td style="border: none;"><input type="radio"/> Bed position</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> <td style="border: none;"><input type="radio"/> Couch position</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> <td style="border: none;"><input type="radio"/> U/K</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> <td style="border: none;">If car seat, was car seat secured in seat of car?</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;"><input type="radio"/> Other, specify:</td> <td style="border: none;"><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</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"/> U/K</td> <td></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></td> <td></td> </tr> </table>				<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	If adult bed, what type?	If futon,	If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Twin	<input type="radio"/> Bed position	<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Full	<input type="radio"/> Couch position	<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> Queen	<input type="radio"/> U/K	<input type="radio"/> Unknown crib type	<input type="radio"/> Bouncy chair	<input type="radio"/> Other, specify:	<input type="radio"/> King	If car seat, was car seat secured in seat of car?	<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> U/K	<input type="radio"/> Other, specify:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair		<input type="radio"/> U/K		<input type="radio"/> Baby box	<input type="radio"/> Floor			
<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	If adult bed, what type?	If futon,																																							
If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Twin	<input type="radio"/> Bed position																																							
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<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair		<input type="radio"/> U/K																																								
<input type="radio"/> Baby box	<input type="radio"/> Floor																																										

<p>b. Child put to sleep:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>c. Child found:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>e. Usual sleep position:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><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>
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<p>d. Usual sleep place:</p> <table style="width:100%; border: none;"> <tr> <td style="border: none;"><input type="radio"/> Crib</td> <td style="border: none;"><input type="radio"/> Baby box</td> <td style="border: none;"><input type="radio"/> Floor</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> </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> </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> </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> </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"/> Bouncy chair</td> </tr> <tr> <td style="border: none;"><input type="radio"/> Bed side sleeper</td> <td style="border: none;"><input type="radio"/> Chair</td> <td style="border: none;"><input type="radio"/> Other, specify:</td> </tr> <tr> <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 crib, type:	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	<input type="radio"/> Not portable	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Unknown crib type	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> Bouncy chair	<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair	<input type="radio"/> Other, specify:			<input type="radio"/> U/K	<p>If adult bed, what type?</p> <p><input type="radio"/> Twin   <input type="radio"/> King</p> <p><input type="radio"/> Full   <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Queen   <input type="radio"/> U/K</p>
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<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair	<input type="radio"/> Other, specify:																									
		<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>
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<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</p> <p><input type="checkbox"/> Too much bedding</p> <p><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>
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<p>l. Child's face when found:</p> <p><input type="radio"/> Down</p> <p><input type="radio"/> Up</p> <p><input type="radio"/> To left or right side</p> <p><input type="radio"/> U/K</p>	<p>m. Child's neck when found:</p> <p><input type="radio"/> Hyperextended (head back)</p> <p><input type="radio"/> Hypoextended (chin to chest)</p> <p><input type="radio"/> Neutral</p> <p><input type="radio"/> Turned</p> <p><input type="radio"/> U/K</p>	<p>n. Child's airway (includes nose, mouth, neck and/or chest):</p> <p><input type="radio"/> Unobstructed by person or object</p> <p><input type="radio"/> Fully obstructed by person or object</p> <p><input type="radio"/> Partially obstructed by person or object</p> <p><input type="radio"/> U/K</p>	<p>If fully or partially obstructed, what was obstructed?</p> <p><input type="checkbox"/> Nose   <input type="checkbox"/> Chest compressed</p> <p><input type="checkbox"/> Mouth   <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Neck compressed</p> <p>If fully or partially obstructed, describe obstruction in detail:</p>
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o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	If present, describe position of object:									If present, did object obstruct airway?			→ If adult(s) obstructed airway, describe relationship of adult to child (for example, biological mother):
	Present?		On top	Under	Next	Tangled	U/K	Yes	No	U/K			
	Yes	No	U/K	of child	child	to child					around child		
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="radio"/>			<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. Caregiver/supervisor fell asleep while feeding child?  
 Yes  No  U/K  
 If yes, type of feeding:  Bottle  Breast  U/K

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

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

If yes, reasons stated for sleeping on same surface, check all that apply:

To feed  
 To soothe  
 Usual sleep pattern  
 No infant bed available  
 Home/living space overcrowded  
 Other, specify: \_\_\_\_\_  
 U/K

If yes, check all that apply:

With adult(s): # \_\_\_\_\_  # U/K  
 Adult obese:  Yes  No  U/K  
 With other children: # \_\_\_\_\_  # U/K Children's ages: \_\_\_\_\_  
 With animal(s): # \_\_\_\_\_  # U/K Type(s) of animal: \_\_\_\_\_

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

**I3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT?**  Yes  No, go to I4  U/K, go to I4

a. Describe product and circumstances:

b. Was product used properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	c. Is a recall in place? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Did product have safety label? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Was Consumer Product Safety Commission (CPSC) notified? <input type="radio"/> Yes <input type="radio"/> No, go to www.saferproducts.gov to report <input type="radio"/> U/K
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**I4. 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:

Robbery/burglary  Other assault  Arson  Illegal border crossing  U/K  
 Interpersonal violence  Gang conflict  Prostitution  Auto theft  
 Sexual assault  Drug trade  Witness intimidation  Other, specify: \_\_\_\_\_

**I5. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS**

<p>a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?</p> <p><input type="radio"/> Yes/probable  <input type="radio"/> No, go to next section  <input type="radio"/> U/K, go to next section</p> <p>If yes/probable, choose primary reason:</p> <p><input type="radio"/> Child abuse, go to I5b  <input type="radio"/> Child neglect, go to I5f  <input type="radio"/> Poor/absent supervision, go to I5h  <input type="radio"/> Exposure to hazards, go to I5g</p>	<p>b. Type of child abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to I5c  <input type="checkbox"/> Chronic Battered Child Syndrome, go to I5e  <input type="checkbox"/> Beating/kicking, go to I5e  <input type="checkbox"/> Scalding or burning, go to I5e  <input type="checkbox"/> Munchausen Syndrome by Proxy, go to I5e  <input type="checkbox"/> Sexual assault, go to I5h  <input type="checkbox"/> Other, specify and go to I5h  <input type="checkbox"/> U/K, go to I5e</p>	<p>c. For abusive head trauma, were there retinal hemorrhages?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <hr/> <p>d. For abusive head trauma, was the child shaken?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was there impact?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>e. Events(s) triggering child abuse, check all that apply:</p> <p><input type="checkbox"/> None  <input type="checkbox"/> Crying  <input type="checkbox"/> Toilet training  <input type="checkbox"/> Disobedience  <input type="checkbox"/> Feeding problems  <input type="checkbox"/> Domestic argument  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K</p>
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<p>f. Child neglect, check all that apply:</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Failure to provide necessities  <input type="checkbox"/> Food  <input type="checkbox"/> Shelter  <input type="checkbox"/> Other, specify:  <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:                  If yes, was this due to religious or cultural practices?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K             </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Exposure to hazards:                  Do not include child's own behavior.  <input type="radio"/> Hazard(s) in sleep environment (including sleep position and bed sharing)  <input type="radio"/> Fire hazard  <input type="radio"/> Unsecured medication/poison  <input type="radio"/> Firearm hazard  <input type="radio"/> Water hazard  <input type="radio"/> Motor vehicle hazard  <input type="radio"/> Other hazard, specify:             </td> </tr> </table>	<input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <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: If yes, was this due to religious or cultural practices? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Exposure to hazards: Do not include child's own behavior. <input type="radio"/> Hazard(s) in sleep environment (including sleep position and bed sharing) <input type="radio"/> Fire hazard <input type="radio"/> Unsecured medication/poison <input type="radio"/> Firearm hazard <input type="radio"/> Water hazard <input type="radio"/> Motor vehicle hazard <input type="radio"/> Other hazard, specify:	<p>g. Exposure to hazards:                  Do not include child's own behavior.  <input type="radio"/> Hazard(s) in sleep environment (including sleep position and bed sharing)  <input type="radio"/> Fire hazard  <input type="radio"/> Unsecured medication/poison  <input type="radio"/> Firearm hazard  <input type="radio"/> Water hazard  <input type="radio"/> Motor vehicle hazard  <input type="radio"/> Maternal substance use during pregnancy  <input type="radio"/> 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>
<input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <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: If yes, was this due to religious or cultural practices? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Exposure to hazards: Do not include child's own behavior. <input type="radio"/> Hazard(s) in sleep environment (including sleep position and bed sharing) <input type="radio"/> Fire hazard <input type="radio"/> Unsecured medication/poison <input type="radio"/> Firearm hazard <input type="radio"/> Water hazard <input type="radio"/> Motor vehicle hazard <input type="radio"/> Other hazard, specify:			

**I6. SUICIDE**

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

Yes	No	U/K		Yes	No	U/K	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away				

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

<input type="checkbox"/> None known <input type="checkbox"/> Family discord <input type="checkbox"/> Parents' divorce/separation <input type="checkbox"/> Argument with parents/caregivers <input type="checkbox"/> Argument with boyfriend/girlfriend <input type="checkbox"/> Breakup with boyfriend/girlfriend <input type="checkbox"/> Argument with other friends <input type="checkbox"/> Emotional neglect/abuse	<input type="checkbox"/> Rumor mongering <input type="checkbox"/> Suicide by friend or relative <input type="checkbox"/> Other death of friend or relative <input type="checkbox"/> Bullying as victim <input type="checkbox"/> Bullying as perpetrator <input type="checkbox"/> School failure <input type="checkbox"/> Move/new school <input type="checkbox"/> Other serious school problems	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Physical abuse/assault <input type="checkbox"/> Rape/sexual abuse <input type="checkbox"/> Problems with the law <input type="checkbox"/> Drugs/alcohol <input type="checkbox"/> Sexual orientation/gender identity <input type="checkbox"/> Job problems <input type="checkbox"/> Money problems	<input type="checkbox"/> Involvement in computer or video games <input type="checkbox"/> Involvement with the Internet, specify: <input type="checkbox"/> U/K
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**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> <p><input type="radio"/> Yes/probable</p> <p><input type="radio"/> No, go to Section K</p> <p><input type="radio"/> U/K, go to Section K</p>	<p>2. What act(s)?</p> <p>Check only one per column and describe in narrative.</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> <td style="width: 20%;"></td> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child abuse</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child neglect</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Poor/absent supervision</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Child abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child neglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Poor/absent supervision	<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 style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<p>4. Is person listed in a previous section?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><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 style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> <td style="width: 20%;"></td> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> <td style="width: 20%;"></td> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Adoptive parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Grandparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Stepparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Sibling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Foster parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Other relative</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Mother's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Friend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Father's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Acquaintance</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child's boyfriend or girlfriend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Stranger</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><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"/>	Adoptive parent	<input type="radio"/>	<input type="radio"/>	Grandparent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stepparent	<input type="radio"/>	<input type="radio"/>	Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foster parent	<input type="radio"/>	<input type="radio"/>	Other relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mother's partner	<input type="radio"/>	<input type="radio"/>	Friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Father's partner	<input type="radio"/>	<input type="radio"/>	Acquaintance	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>	<input type="radio"/>	Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>	<input type="radio"/>	Stranger	<input type="radio"/>	<input type="radio"/>
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<p>6. Person's age in years:</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;"># Years</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	_____	_____	# Years		<input type="checkbox"/>	<input type="checkbox"/>	U/K		<p>7. Person's sex:</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Male</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Female</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Male		<input type="radio"/>	<input type="radio"/>	Female		<input type="radio"/>	<input type="radio"/>	U/K		<p>8. Person speaks and understands English?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If no, language spoken:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<p>9. Person on active military duty?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, specify branch:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K	
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<p>10. Person(s) have history of substance abuse?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Alcohol</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cocaine</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Marijuana</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Methamphetamine</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Opiates</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Prescription drugs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Over-the-counter</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	Opiates	<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>11. Person(s) have history of child maltreatment as victim?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Physical</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neglect</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexual</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Emotional/psychological</td> </tr> <tr> <td><input type="checkbox"/></td> <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"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Sexual	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychological	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Physical</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neglect</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexual</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Emotional/psychological</td> </tr> <tr> <td><input type="checkbox"/></td> <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"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Sexual	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychological	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>13. Person(s) have disability or chronic illness?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Physical/orthopedic, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental health/substance abuse, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cognitive/intellectual, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sensory, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table> <p>If mental health/substance abuse, was person receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<input type="checkbox"/>	<input type="checkbox"/>	Physical/orthopedic, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Mental health/substance abuse, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive/intellectual, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Sensory, specify:	<input type="checkbox"/>	<input type="checkbox"/>	U/K
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<p>14. Person(s) have prior child deaths?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Child abuse # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Child neglect # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Accident # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Suicide # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">SIDS # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Undetermined cause # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Other # _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Other, specify:</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	Child abuse # _____		<input type="checkbox"/>	<input type="checkbox"/>	Child neglect # _____		<input type="checkbox"/>	<input type="checkbox"/>	Accident # _____		<input type="checkbox"/>	<input type="checkbox"/>	Suicide # _____		<input type="checkbox"/>	<input type="checkbox"/>	SIDS # _____		<input type="checkbox"/>	<input type="checkbox"/>	Undetermined cause # _____		<input type="checkbox"/>	<input type="checkbox"/>	Other # _____		<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:		<input type="checkbox"/>	<input type="checkbox"/>	U/K		<p>15. Person(s) have history of intimate partner violence?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Yes, as victim</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Yes, as perpetrator</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	Yes, as victim		<input type="checkbox"/>	<input type="checkbox"/>	Yes, as perpetrator		<input type="checkbox"/>	<input type="checkbox"/>	No		<input type="checkbox"/>	<input type="checkbox"/>	U/K		<p>16. Person(s) have delinquent/criminal history?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Assaults</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Robbery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Drugs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<input type="checkbox"/>	<input type="checkbox"/>	Assaults	<input type="checkbox"/>	<input type="checkbox"/>	Robbery	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	U/K
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<p>17. At the time of the incident, was the person asleep?</p> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Yes</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">U/K</td> <td></td> </tr> </table> <p>If yes, select the most appropriate description of the person's sleeping period at incident:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Yes		<input type="radio"/>	<input type="radio"/>	No		<input type="radio"/>	<input type="radio"/>	U/K		<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Night time sleep</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Day time nap, describe:</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Day time sleep (for example, person is night shift worker), describe:</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Other, describe:</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	Night time sleep		<input type="radio"/>	<input type="radio"/>	Day time nap, describe:		<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:	
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Other, describe:																																	



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

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

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

**M. THE REVIEW MEETING PROCESS**

1. Date of first review meeting:	2. Number of review meetings for this case: _____	3. Is review complete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No
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4. Agencies and individuals at review meeting, check all that apply:

<input type="checkbox"/> Medical examiner/coroner	<input type="checkbox"/> CPS	<input type="checkbox"/> Other health care	<input type="checkbox"/> Mental health	<input type="checkbox"/> Child advocate
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Other social services	<input type="checkbox"/> Fire	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Military
<input type="checkbox"/> Prosecutor/district attorney	<input type="checkbox"/> Physician	<input type="checkbox"/> EMS	<input type="checkbox"/> Home visiting	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Public health	<input type="checkbox"/> Nurse	<input type="checkbox"/> Faith based organization	<input type="checkbox"/> Healthy Start	<input type="checkbox"/> Others, list:
<input type="checkbox"/> HMO/managed care	<input type="checkbox"/> Hospital	<input type="checkbox"/> Education	<input type="checkbox"/> Court	

<p>5. Were the following data sources available at the review meeting?</p> <p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> CDC's SUIDI Reporting Form</li> <li><input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form</li> <li><input type="checkbox"/> Birth certificate - full form</li> <li><input type="checkbox"/> Death certificate</li> <li><input type="checkbox"/> Child's medical records or clinical history, including vaccinations</li> <li><input type="checkbox"/> Biological mother's obstetric and prenatal information</li> <li><input type="checkbox"/> Newborn screening results</li> <li><input type="checkbox"/> Law enforcement records</li> <li><input type="checkbox"/> Social service records</li> <li><input type="checkbox"/> Child protection agency records</li> <li><input type="checkbox"/> EMS run sheet</li> <li><input type="checkbox"/> Hospital records</li> <li><input type="checkbox"/> Autopsy/pathology reports</li> <li><input type="checkbox"/> Home visiting</li> <li><input type="checkbox"/> Mental health records</li> <li><input type="checkbox"/> School records</li> <li><input type="checkbox"/> Substance abuse treatment records</li> </ul>	<p>6. Did any of the following factors reduce meeting effectiveness, check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Confidentiality issues among members prevented full exchange of information</li> <li><input type="checkbox"/> HIPAA regulations prevented access to or exchange of information</li> <li><input type="checkbox"/> Inadequate investigation precluded having enough information for review</li> <li><input type="checkbox"/> Team members did not bring adequate information to the meeting</li> <li><input type="checkbox"/> Necessary team members were absent</li> <li><input type="checkbox"/> Meeting was held too soon after death</li> <li><input type="checkbox"/> Meeting was held too long after death</li> <li><input type="checkbox"/> Records or information were needed from another locality in-state</li> <li><input type="checkbox"/> Records or information were needed from another state</li> <li><input type="checkbox"/> Team disagreement on circumstances</li> <li><input type="checkbox"/> Other factors, specify:</li> </ul>
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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: 12/31/2018

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, including case details that helped determine SDY categorization and any ways to improve the review:												
4. Professionals at the Advanced Review meeting, check all that apply:													
<table border="0"> <tr> <td><input type="checkbox"/> Cardiologist</td> <td><input type="checkbox"/> Death investigator</td> <td><input type="checkbox"/> Geneticist or genetic counselor</td> <td><input type="checkbox"/> Pediatrician</td> </tr> <tr> <td><input type="checkbox"/> CDR representative</td> <td><input type="checkbox"/> Epileptologist</td> <td><input type="checkbox"/> Mental health professional</td> <td><input type="checkbox"/> Public health representative</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> Forensic pathologist/medical examiner</td> <td><input type="checkbox"/> Neonatologist</td> <td><input type="checkbox"/> Others, specify:</td> </tr> </table>		<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Death investigator	<input type="checkbox"/> Geneticist or genetic counselor	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> CDR representative	<input type="checkbox"/> Epileptologist	<input type="checkbox"/> Mental health professional	<input type="checkbox"/> Public health representative	<input type="checkbox"/> Coroner	<input type="checkbox"/> Forensic pathologist/medical examiner	<input type="checkbox"/> Neonatologist	<input type="checkbox"/> Others, specify:
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<input type="checkbox"/> Coroner	<input type="checkbox"/> Forensic pathologist/medical examiner	<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 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>	<p>8. 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>
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9. Categorization for SDY Case Registry (choose only one):

<input type="radio"/> Excluded from SDY Case Registry	<input type="radio"/> Explained neurological	<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		<input type="radio"/> Unexplained, possible cardiac and SUDEP	

10. 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:
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**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:	<b>For State Program Use Only:</b> Data quality assurance completed by state? <input type="checkbox"/>



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 Data Entry: <https://data.ncfrp.org>  
[www.ncfrp.org](http://www.ncfrp.org)    [info@ncfrp.org](mailto:info@ncfrp.org)    1-800-656-2434    Facebook and Twitter: NationalCFRP