

# FIMR REPORT FORM

*Version 6.0*

## National Fatality Review Case Reporting System

Data Entry Website: [data.ncfrp.org](http://data.ncfrp.org)

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@nationalcfrp



# SAVING LIVES TOGETHER

## Instructions:

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

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

It is not expected that teams will have answers to all of the questions 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** as a PDF in the Help menu or as individual help icons in the online data entry system. 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.

Throughout the form, a plus sign (+) beside a question indicates that it is skipped for fetal deaths.

## Reminder:

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

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

CASE NUMBER			
_____ / _____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious injury <input type="radio"/> Not born alive (fetal/stillborn)	Death Certificate Number: Birth Certificate Number: ME/Coroner Number:	
<input type="checkbox"/> Child never left hospital following birth		Date Team Notified of Death:	
A. CHILD INFORMATION			
A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)		A * symbol means that the question is skipped for fetal deaths.	
1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K			
2. Date of birth: <input type="checkbox"/> U/K _____/_____/_____ mm dd yyyy	3. Date of death: <input type="checkbox"/> U/K _____/_____/_____ mm dd yyyy	5. Race, check all that apply: <input type="checkbox"/> Alaska Native, Tribe: _____ <input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> White <input type="checkbox"/> U/K	6. Hispanic or Latino/a origin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
4. Age*: <input type="radio"/> Years <input type="radio"/> Hours <input type="radio"/> Months <input type="radio"/> Minutes <input type="radio"/> Days <input type="radio"/> U/K		8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____	
9. Child's weight at death*: <input type="checkbox"/> U/K <input type="radio"/> Pounds/ounces _____ <input type="radio"/> Grams/kilograms _____		11. State of death: _____	
10. Child's height at death*: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ <input type="radio"/> Cm _____		12. County of death: _____	
13. Child had disability or chronic illness*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical/orthopedic, specify: <input type="checkbox"/> Mental health/substance abuse, specify: <input type="checkbox"/> Cognitive/intellectual, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		14. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K	
15. Child's health insurance, check all that apply*: <input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Indian Health Service <input type="checkbox"/> U/K <input type="checkbox"/> Private <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: _____		16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule*? <input type="radio"/> NA <input type="radio"/> Yes <input type="radio"/> No, specify: _____ <input type="radio"/> U/K	
17. Household income: <input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low <input type="radio"/> U/K		If the child never left the hospital following birth, go to A3.	
18. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K		19. New residence in past 30 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	20. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 21. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
22. Number of other children living with child: _____ <input type="checkbox"/> U/K		23. Child had history of child maltreatment as victim? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K    If yes, how was history identified: If yes, check all that apply: <input type="radio"/> Through CPS <input type="checkbox"/> Physical <input type="radio"/> Other sources <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual    If through CPS: _____ # CPS referrals <input type="checkbox"/> Emotional/psychological    _____ # Substantiations <input type="checkbox"/> U/K	
24. Was there an open CPS case with child at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		25. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
26. How many months prior to death did child last have contact with a health care provider? _____		A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR    Questions 27 - 42 (Section A2) are intentionally skipped; * means skipped for fetal deaths.	
43. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
44. Gestational age: <input type="checkbox"/> U/K _____ # weeks	45. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____	46. Multiple gestation pregnancy? <input type="radio"/> Yes, # of fetuses _____ <input type="radio"/> No <input type="radio"/> U/K	47. Including the deceased infant, how many pregnancies did the childbearing parent have? # _____ <input type="checkbox"/> U/K
48. Including the deceased infant, how many live births did the childbearing parent have? # _____ <input type="checkbox"/> U/K			
49. Not including the deceased infant, number of children childbearing parent still has living? # _____ <input type="checkbox"/> U/K		50. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, number of prenatal visits kept: # _____ <input type="checkbox"/> U/K If yes, month of first prenatal visit. Specify 1-9: _____ <input type="checkbox"/> U/K	

51. Were there access or barrier issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:			
<input type="checkbox"/> Lack of money for care		<input type="checkbox"/> Couldn't get provider to take as patient	
<input type="checkbox"/> Limitations of health insurance coverage		<input type="checkbox"/> Multiple providers, not coordinated	
<input type="checkbox"/> Lack of transportation		<input type="checkbox"/> Couldn't get an earlier appointment	
<input type="checkbox"/> No phone		<input type="checkbox"/> Lack of child care	
<input type="checkbox"/> Language barriers		<input type="checkbox"/> Lack of family/social support	
<input type="checkbox"/> Services not available		<input type="checkbox"/> Distrust of health care system	
<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Unwilling to obtain care	
		<input type="checkbox"/> U/K	
		<input type="checkbox"/> Didn't know where to go	
		<input type="checkbox"/> Didn't think they were pregnant	
53. Did the childbearing parent experience any medical complications in previous pregnancies?			
<input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
<input type="checkbox"/> Previous preterm birth		<input type="checkbox"/> Previous small for gestational age	
If yes, check all that apply:			
<input type="checkbox"/> Previous low birth weight birth		<input type="checkbox"/> Previous large for gestational age (greater than 4000 grams)	
54. Did the childbearing parent use any medications, drugs or other substances during pregnancy?			
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:			
<input type="checkbox"/> Over-the-counter meds		<input type="checkbox"/> Anti-epileptic	
<input type="checkbox"/> Allergy medications		<input type="checkbox"/> Anti-hypertensives	
<input type="checkbox"/> Antibiotics		<input type="checkbox"/> Anti-hypothyroidism	
<input type="checkbox"/> Anti-depressants/anti-anxiety/anti-psychotics		<input type="checkbox"/> Arthritis medications	
		<input type="checkbox"/> Diabetes medications	
		<input type="checkbox"/> Asthma medications	
		<input type="checkbox"/> Nausea/vomiting medications	
		<input type="checkbox"/> Cholesterol medications	
		<input type="checkbox"/> Meds to treat preterm labor	
		<input type="checkbox"/> Meds used during delivery	
		<input type="checkbox"/> Progesterone/P17	
		<input type="checkbox"/> Cocaine	
		<input type="checkbox"/> Heroin	
		<input type="checkbox"/> Marijuana	
		<input type="checkbox"/> Methamphetamine	
		<input type="checkbox"/> Alcohol	
		<input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome?	
		<input type="checkbox"/> Meds to treat drug addiction	
		<input type="checkbox"/> Opioids	
		<input type="checkbox"/> Other pain meds	
		<input type="checkbox"/> Other, specify:	
		<input type="checkbox"/> U/K	
If any item is checked, please indicate the generic or brand name of the medications or drugs:			
55. Was the infant/fetus born drug exposed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		56. Did the infant have neonatal abstinence syndrome (NAS)*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
57. Level of birth hospital:		58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent?	
<input type="radio"/> 1		<input type="radio"/> N/A, childbearing parent did not go to a birth hospital	
<input type="radio"/> 2		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<input type="radio"/> 3		59. Did the childbearing parent have contact with their care provider within the first 3 weeks postpartum?	
<input type="radio"/> 4		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<input type="radio"/> Freestanding birth center		60. 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	
<input type="radio"/> Home birth		If yes, for what reason(s)? Check all that apply:	
<input type="radio"/> Other, specify:		<input type="checkbox"/> Prematurity	
<input type="radio"/> U/K		<input type="checkbox"/> Apnea	
		<input type="checkbox"/> Hypothermia	
		<input type="checkbox"/> Meconium aspiration	
		<input type="checkbox"/> Low birth weight	
		<input type="checkbox"/> Sepsis	
		<input type="checkbox"/> Jaundice	
		<input type="checkbox"/> Congenital anomalies	
		<input type="checkbox"/> Tachypnea	
		<input type="checkbox"/> Feeding difficulties	
		<input type="checkbox"/> Anemia	
		<input type="checkbox"/> Other, specify:	
		<input type="checkbox"/> U/K	
		<input type="checkbox"/> Drug/alcohol exposure	
61. Did the childbearing parent smoke in the 3 months before pregnancy?		62. Did the childbearing parent smoke at any time during pregnancy?	
<input type="radio"/> Yes		<input type="radio"/> Yes	
If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)		<input type="radio"/> No	
<input type="radio"/> No		<input type="radio"/> U/K	
<input type="radio"/> U/K		<input type="checkbox"/> U/K quantity	
		Trimester 1    Trimester 2    Trimester 3	
		If yes, _____ Avg # cigarettes/day (20 cigarettes in pack)	
		<input type="checkbox"/> U/K quantity	
63. Did the childbearing parent use e-cigarettes or other electronic nicotine products at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
If yes, on average how often? <input type="radio"/> More than once a day <input type="radio"/> Once a day <input type="radio"/> 2-6 days a week <input type="radio"/> 1 day a week or less <input type="radio"/> U/K			
64. Was the childbearing parent injured during pregnancy?		65. Did the childbearing parent have postpartum depression?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
If yes, describe:			
If this was a fetal death, go to Section A4.			
66. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		67. Did infant have abnormal metabolic newborn screening results?	
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		<input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		If yes, describe any abnormality such as a fatty acid oxidation error:	
If yes, any breast milk at 6 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
If ever, was infant receiving breast milk at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
If the infant never left the hospital following birth, go to Section A4.			
68. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):		69. In the 72 hours prior to death, did the infant have any of the following?	
<input type="checkbox"/> None		Check all that apply:	
<input type="checkbox"/> Infection		<input type="checkbox"/> None	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Decrease in appetite	
<input type="checkbox"/> Abnormal growth, weight gain/loss		<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Apnea		<input type="checkbox"/> Choking	
<input type="checkbox"/> Cyanosis		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Seizures or convulsions		<input type="checkbox"/> Stool changes	
<input type="checkbox"/> Cardiac abnormalities		<input type="checkbox"/> Difficulty breathing	
<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Fussiness/excessive crying	
<input type="checkbox"/> U/K		<input type="checkbox"/> U/K	

70. In the 72 hours prior to death, was the infant injured? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe cause and injuries:	71. In the 72 hours prior to death, was the infant given any vaccines? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name(s) of vaccines:	72. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name and last dose given:	73. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Baby food <input type="checkbox"/> Cereal <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K
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**A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR** A + symbol means that the question is skipped for fetal deaths.

74. Name of childbearing biological parent (CBP): First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Maiden: \_\_\_\_\_  U/K

75. Name of non-childbearing biological parent (Non-CBP): First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  U/K

76. Childbearing parent's country of birth:  U/K

78. Childbearing parent's residence address: <input type="checkbox"/> Same as child Street: _____ <input type="checkbox"/> U/K Apt. _____ City: _____ State: _____ Zip: _____ County: _____	79. Childbearing parent's marital status during pregnancy: <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> U/K	80. Number of months between <input type="checkbox"/> U/K prior pregnancy and this one: 81. Was childbearing parent taking folic acid or a multivitamin prior to this pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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82. Childbearing parent's employment during pregnancy: <input type="radio"/> Employed If employed, did they think it was physically hard? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Unemployed <input type="radio"/> On disability If employed, did they think the job was stressful? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Stay-at-home <input type="radio"/> Student If employed or student, number of weeks post-delivery started or returned: <input type="radio"/> U/K If employed or student, who watched the infant? Describe:	83. Childbearing parent's pre-pregnancy weight, height, BMI: Weight in pounds (whole number): _____ lbs <input type="checkbox"/> U/K Height in feet and inches (whole numbers): _____ ft _____ in <input type="checkbox"/> U/K BMI will be calculated automatically if both height and weight are available. If you don't have height and weight but know the pre-pregnancy BMI, you can enter it: 84. Childbearing parent's pregnancy weight gain or loss in pounds (whole number) Enter a negative number for weight loss: _____ lbs <input type="checkbox"/> U/K 85. Did childbearing parent achieve the recommended weight gain? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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86. Childbearing parent's age at first pregnancy:  U/K

87. For each previous pregnancy, describe most recent first:  N/A \*Outcome Codes: 1 - Full-term, live birth

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

2 - Premature live birth  
 3 - Stillbirth > or = 20 weeks  
 4 - Spontaneous abortion/miscarriage/Stillbirth < 20 weeks  
 5 - Therapeutic abortion  
 6 - Voluntary abortion  
 7 - Ectopic  
 9 - U/K

88. Was childbearing parent using birth control in the 3 months prior to this pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what type? <input type="radio"/> LARC including implants/IUDs <input type="radio"/> Natural, withdrawal, pull out, rhythm method <input type="radio"/> Oral contraceptives, specify: _____ <input type="radio"/> Barrier methods (male/female condoms/cervical cap) <input type="radio"/> Tubal ligation <input type="radio"/> Injections (Depo Provera) <input type="radio"/> Multiple methods <input type="radio"/> Spermicides <input type="radio"/> Other, specify: _____ <input type="radio"/> U/K If no, was pregnancy: <input type="radio"/> Unintended <input type="radio"/> Intended <input type="radio"/> Mistimed <input type="radio"/> U/K	89. Where was prenatal care most frequently provided for this pregnancy? <input type="radio"/> N/A <input type="radio"/> Private provider's office <input type="radio"/> County or city health department <input type="radio"/> Clinic <input type="radio"/> Managed care organization <input type="radio"/> Community/neighborhood health center <input type="radio"/> Other, specify type: _____ <input type="radio"/> U/K	90. Which type of provider most frequently provided prenatal care for this pregnancy? <input type="radio"/> N/A <input type="radio"/> Nurse practitioner <input type="radio"/> OB <input type="radio"/> Nurse midwife <input type="radio"/> Perinatologist <input type="radio"/> Family physician <input type="radio"/> Other, specify type: _____ <input type="radio"/> U/K
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91. Was this pregnancy a result of assisted reproductive technology?  Yes  No  U/K  
 If yes, describe:

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

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

93. Did the childbearing parent receive the following vaccinations during pregnancy?  Tdap  Seasonal flu

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

Timeframe	Referrals during this pregnancy
1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy	1 - No referral, not needed
2 - Began previous to this pregnancy AND includes current pregnancy	2 - No referral, already in care
3 - Began during this current pregnancy	3 - No referral, needed
4 - Began during labor and delivery	4 - Referral made, services not provided
9 - U/K	5 - Referral made, services provided
	9 - U/K

If yes, check all that apply:

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

<p>95. Did the care provider recommend precautions to prevent premature labor or early labor? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, what precautions? <span style="float:right">If yes for a precaution, was there a barrier or system issue that prevented the advice from being followed?</span></p> <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Took medicine to prevent labor or miscarriage</td> <td style="width:50%; border:none;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Received progesterone IM or vaginal progesterone</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="checkbox"/> Stopped or limited sex during pregnancy</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="checkbox"/> Used condoms to prevent infection</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="checkbox"/> Placement of cervical cerclage</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="checkbox"/> Had bed rest for one or more weeks at home</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="checkbox"/> Was hospitalized for one or more nights</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="checkbox"/> Reduced work hours or stopped working earlier than expected</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="checkbox"/> Reduced housework or other physical activities</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="checkbox"/> Other, specify:</td> <td style="border:none;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> </tr> </table>		<input type="checkbox"/> Took medicine to prevent labor or miscarriage	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Received progesterone IM or vaginal progesterone	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Stopped or limited sex during pregnancy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Used condoms to prevent infection	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Placement of cervical cerclage	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Had bed rest for one or more weeks at home	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Was hospitalized for one or more nights	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Reduced work hours or stopped working earlier than expected	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Reduced housework or other physical activities	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Other, specify:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																													
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<p>96. Type of delivery: <span style="float:right">If C-Section, why was it done?</span></p> <table style="width:100%; border:none;"> <tr> <td style="width:25%; border:none;"><input type="checkbox"/> Routine</td> <td style="width:25%; border:none;"><input type="checkbox"/> Vaginal delivery after C-Section (VBAC)</td> <td style="width:25%; border:none;"><input type="checkbox"/> Failure to progress</td> <td style="width:25%; border:none;"><input type="checkbox"/> Malpresentation</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Emergency</td> <td style="border:none;"><input type="checkbox"/> C-Section</td> <td style="border:none;"><input type="checkbox"/> Fetal distress</td> <td style="border:none;"><input type="checkbox"/> Repeat C-Section</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Normal spontaneous vaginal delivery (NSVD)</td> <td style="border:none;"><input type="checkbox"/> Forceps</td> <td style="border:none;"><input type="checkbox"/> Macrosomia</td> <td style="border:none;"><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Vaginal, induced or augmented</td> <td style="border:none;"><input type="checkbox"/> Vacuum extraction</td> <td style="border:none;"><input type="checkbox"/> Placental abruption</td> <td style="border:none;"><input type="checkbox"/> U/K</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> U/K</td> <td style="border:none;"><input type="checkbox"/> U/K</td> <td style="border:none;"><input type="checkbox"/> Placental Previa</td> <td style="border:none;"><input type="checkbox"/> U/K</td> </tr> </table>		<input type="checkbox"/> Routine	<input type="checkbox"/> Vaginal delivery after C-Section (VBAC)	<input type="checkbox"/> Failure to progress	<input type="checkbox"/> Malpresentation	<input type="checkbox"/> Emergency	<input type="checkbox"/> C-Section	<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Repeat C-Section	<input type="checkbox"/> Normal spontaneous vaginal delivery (NSVD)	<input type="checkbox"/> Forceps	<input type="checkbox"/> Macrosomia	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Vaginal, induced or augmented	<input type="checkbox"/> Vacuum extraction	<input type="checkbox"/> Placental abruption	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<input type="checkbox"/> Placental Previa	<input type="checkbox"/> U/K																													
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<p>97. Were there any signs of fetal distress? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>100. Was there evidence of injury at death, not including the birth process+? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, what type(s) of injury?</p> <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Contusion/bruises</td> <td style="width:50%; border:none;"><input type="checkbox"/> Abrasions/scratches</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Fractures</td> <td style="border:none;"><input type="checkbox"/> Resuscitative marks</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Cigarette burns</td> <td style="border:none;"><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Hemorrhage</td> <td style="border:none;"></td> </tr> </table>	<input type="checkbox"/> Contusion/bruises	<input type="checkbox"/> Abrasions/scratches	<input type="checkbox"/> Fractures	<input type="checkbox"/> Resuscitative marks	<input type="checkbox"/> Cigarette burns	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Hemorrhage		<p>101. Was a placental pathology performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe findings:</p>																																								
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<p>98. Were any birth defects noted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>	<p>99. Date of childbearing parent's discharge from the birth hospital: _____</p> <p style="text-align:center">mm / dd / yyyy <span style="margin-left: 100px;"><input type="radio"/> N/A <input type="radio"/> U/K</span></p>																																																	
<p>102. Payer source for childbearing parent's care for the following timeframes, check all that apply:</p> <table style="width:100%; border:none;"> <thead> <tr> <th></th> <th style="text-align:center">Pre</th> <th style="text-align:center">Preg</th> <th style="text-align:center">L&amp;D</th> <th style="text-align:center">Post</th> </tr> </thead> <tbody> <tr> <td>None</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>Private insurance</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>Medicaid</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>State plan</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>Indian Health Service</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>Other, specify:</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>U/K</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </tbody> </table>		Pre	Preg	L&D	Post	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Private insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	State plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>103. Did the childbearing parent have stable housing during the pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, indicate the type(s) of instability:</p> <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Parent in jail</td> <td style="width:50%; border:none;"><input type="checkbox"/> Homeless</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Eviction(s)</td> <td style="border:none;"><input type="checkbox"/> More than 3 moves in past year</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Other, specify:</td> <td style="border:none;"></td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> U/K</td> <td style="border:none;"></td> </tr> </table>	<input type="checkbox"/> Parent in jail	<input type="checkbox"/> Homeless	<input type="checkbox"/> Eviction(s)	<input type="checkbox"/> More than 3 moves in past year	<input type="checkbox"/> Other, specify:		<input type="checkbox"/> U/K		<p>104. Did the childbearing parent have phone service during the pregnancy? <input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always <input type="radio"/> U/K</p>
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<p>105. Did the childbearing parent have any high-risk prenatal/ antepartum encounters? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, number of visits with primary care provider: _____</p> <p>If yes, number of L&amp;D/triage/ED visits, excluding the birth: _____</p>	<p>106. Did the childbearing parent have any hospitalizations greater than 24 hours prior to labor and delivery excluding the birth? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, what treatment was recommended?</p>																																																	
<p>107. Did childbearing parent die as a result of a pregnancy related condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																																																		
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<p>109. Were any health education topics discussed at any time between the first prenatal care visit and the delivery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which topic(s)?</p> <table style="width:100%; border:none;"> <tr> <td style="width:33%; border:none;"><input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent</td> <td style="width:33%; border:none;"><input type="checkbox"/> Signs and symptoms of pregnancy-induced hypertension</td> <td style="width:33%; border:none;"><input type="checkbox"/> Preparing to breastfeed</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Where to go for care in case of emergency</td> <td style="border:none;"><input type="checkbox"/> HIV testing</td> <td style="border:none;"><input type="checkbox"/> Safe sleep education</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Current medications</td> <td style="border:none;"><input type="checkbox"/> Childbearing parent's vaccinations</td> <td style="border:none;"><input type="checkbox"/> Importance of keeping postpartum visits</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Environmental/work hazards</td> <td style="border:none;"><input type="checkbox"/> Risk factors identified by prenatal history</td> <td style="border:none;"><input type="checkbox"/> Postpartum (perinatal) depression</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Childbearing parent nutrition</td> <td style="border:none;"><input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange)</td> <td style="border:none;"><input type="checkbox"/> Family planning (spacing, interconception care, etc.)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Weight gain counseling</td> <td style="border:none;"><input type="checkbox"/> Illicit/recreational drugs</td> <td style="border:none;"><input type="checkbox"/> Postpartum family planning/tubal sterilization</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Eating disorders such as anorexia or bulimia</td> <td style="border:none;"><input type="checkbox"/> Fetal movement monitoring</td> <td style="border:none;"><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Exercise</td> <td style="border:none;"><input type="checkbox"/> Kick counts</td> <td style="border:none;"></td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Labor signs</td> <td style="border:none;"><input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding</td> <td style="border:none;"></td> </tr> </table>			<input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent	<input type="checkbox"/> Signs and symptoms of pregnancy-induced hypertension	<input type="checkbox"/> Preparing to breastfeed	<input type="checkbox"/> Where to go for care in case of emergency	<input type="checkbox"/> HIV testing	<input type="checkbox"/> Safe sleep education	<input type="checkbox"/> Current medications	<input type="checkbox"/> Childbearing parent's vaccinations	<input type="checkbox"/> Importance of keeping postpartum visits	<input type="checkbox"/> Environmental/work hazards	<input type="checkbox"/> Risk factors identified by prenatal history	<input type="checkbox"/> Postpartum (perinatal) depression	<input type="checkbox"/> Childbearing parent nutrition	<input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange)	<input type="checkbox"/> Family planning (spacing, interconception care, etc.)	<input type="checkbox"/> Weight gain counseling	<input type="checkbox"/> Illicit/recreational drugs	<input type="checkbox"/> Postpartum family planning/tubal sterilization	<input type="checkbox"/> Eating disorders such as anorexia or bulimia	<input type="checkbox"/> Fetal movement monitoring	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Exercise	<input type="checkbox"/> Kick counts		<input type="checkbox"/> Labor signs	<input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding																						
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<input type="checkbox"/> Eating disorders such as anorexia or bulimia	<input type="checkbox"/> Fetal movement monitoring	<input type="checkbox"/> Other, specify:																																																
<input type="checkbox"/> Exercise	<input type="checkbox"/> Kick counts																																																	
<input type="checkbox"/> Labor signs	<input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding																																																	

110. Were any health education topics discussed at any time between childbearing parent's admission and discharge from the birth hospital?  
 Yes  No  U/K If yes, which topic(s)?

<input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent	<input type="checkbox"/> Childbearing parent's vaccinations	<input type="checkbox"/> Postpartum (perinatal) depression
<input type="checkbox"/> Where to go for care in case of emergency	<input type="checkbox"/> Tobacco (Ask, Advise, Assess, Assist, and Arrange)	<input type="checkbox"/> Family planning (spacing, interconception care, etc.)
<input type="checkbox"/> Current medications	<input type="checkbox"/> Illicit/recreational drugs	<input type="checkbox"/> Postpartum family planning/tubal sterilization
<input type="checkbox"/> Childbearing parent nutrition	<input type="checkbox"/> Choosing how to feed infant/benefits of breastfeeding	<input type="checkbox"/> Interconception care
<input type="checkbox"/> Eating disorders such as anorexia or bulimia	<input type="checkbox"/> Breastfeeding education	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Exercise	<input type="checkbox"/> Bottle feeding education	
<input type="checkbox"/> HIV testing	<input type="checkbox"/> Safe sleep education	
	<input type="checkbox"/> Importance of keeping postpartum visits	

111. Were any infant safety topics discussed at any time between the first prenatal care visit and childbearing parent's discharge from the birth hospital?  
 Yes  No  U/K If yes, which topic(s)?

<input type="checkbox"/> Bath safety	<input type="checkbox"/> Signs/symptoms that warrant medical attention in the childbearing parent	<input type="checkbox"/> Abusive Head Trauma/Shaken Baby Syndrome	<input type="checkbox"/> Use of infant car seat
<input type="checkbox"/> Infant care	<input type="checkbox"/> Parenting skills	<input type="checkbox"/> SUID/Safe sleep education	<input type="checkbox"/> Where to go for care in case of infant emergency
<input type="checkbox"/> Infant signs/symptoms that warrant medical attention	<input type="checkbox"/> Protection from falls	<input type="checkbox"/> Small object avoidance	<input type="checkbox"/> Other, specify:
		<input type="checkbox"/> Use of home smoke detector	

112. Did the childbearing parent experience any stressors during the pregnancy?  Yes  No  U/K If yes, which one(s)?

<input type="checkbox"/> A close family member was very sick	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Separated or divorced from partner	<input type="checkbox"/> Involved in a physical fight	<input type="checkbox"/> Emotional abuse
<input type="checkbox"/> Lost job	<input type="checkbox"/> Childbearing parent or partner went to jail	<input type="checkbox"/> Someone very close to them died
<input type="checkbox"/> Partner lost job	<input type="checkbox"/> Someone very close to the childbearing parent had a problem with drinking alcohol or drugs	<input type="checkbox"/> Afraid of violence in their neighborhood
<input type="checkbox"/> Childbearing parent and partner argued more than usual	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Childbearing parent's partner said they did not want the childbearing parent to be pregnant		

113. Was the childbearing parent a victim of intimate partner violence? \* Referral key:

<u>CBP as victim:</u> Y N U/K	Referral*	1 - No referral, not needed	5 - Referral made, services provided
Preconception <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="text"/>	2 - No referral, already in service	9 - U/K
Pregnancy <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="text"/>	3 - No referral, needed	
Postpartum <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="text"/>	4 - Referral made, services not provided	

114. Was the family referred to any health or human services program during or after the pregnancy?  Yes  No  U/K  
If any of these are checked, note whether a referral was made using the following responses:

Referral options:	1 - Referral made, services not provided	2 - Referral made, services provided	9 - U/K
<input type="checkbox"/> Case management	Referral:	<input type="checkbox"/> Drug treatment program	Referral:
<input type="checkbox"/> Infant/child health program	Referral:	<input type="checkbox"/> Smoking cessation program	Referral:
<input type="checkbox"/> Child Protection Services	Referral:	<input type="checkbox"/> Alcohol cessation program	Referral:
<input type="checkbox"/> Legal aid	Referral:	<input type="checkbox"/> Housing authority	Referral:
<input type="checkbox"/> Evidence-based home visiting	Referral:	<input type="checkbox"/> Shelters	Referral:
<input type="checkbox"/> Family planning	Referral:	<input type="checkbox"/> Unemployment assistance	Referral:
<input type="checkbox"/> Mental health service	Referral:	<input type="checkbox"/> Homemaker/home health aide	Referral:
<input type="checkbox"/> Infant mental health program	Referral:	<input type="checkbox"/> Medicaid	Referral:
<input type="checkbox"/> Genetic evaluation/counseling	Referral:	<input type="checkbox"/> WIC	Referral:
<input type="checkbox"/> GED programs	Referral:	<input type="checkbox"/> TANF	Referral:
<input type="checkbox"/> Children's Special Health Care Needs	Referral:	<input type="checkbox"/> SNAP	Referral:

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

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

116 Apgar: 1 min:      5 min:      10 min:       U/K

117. Were neonatal resuscitation measures required or attempted in delivery room?  Yes  No  U/K  
If yes, which measure(s)?

<input type="checkbox"/> Physical stimulation
<input type="checkbox"/> Intubation
<input type="checkbox"/> Respiratory or cardiac meds for resuscitation
<input type="checkbox"/> Oxygen
<input type="checkbox"/> Other, specify:

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

<input type="checkbox"/> Normal newborn nursery
<input type="checkbox"/> Rooming in
<input type="checkbox"/> Observation/special care nursery (NICU, intensive care or premature nursery) If yes, admitting diagnosis:
<input type="checkbox"/> Transferred to another hospital
<input type="checkbox"/> Other, specify:
<input type="checkbox"/> U/K



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

If yes, what were they?

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

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

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

If positive, for what?

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

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

121. Date of infant's last discharge from any hospital: __/__/__ <input type="checkbox"/> U/K	126. Was the infant technologically dependent on discharge from any hospital visit? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:
122. Total number of days infant hospitalized: <input type="checkbox"/> U/K	
123. Infant's disposition (after birth, from any hospital): <input type="radio"/> Home with parents <input type="radio"/> Other, specify: <input type="radio"/> U/K	
124. Did the infant have a primary care provider? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
125. Were any medications prescribed for the infant at any discharge? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify: If yes, were parents instructed in medication administration? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	127. After the infant came home from the hospital after delivery, did s/he have to go back into the hospital overnight for any reason? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many nights was the infant in the hospital? Number of nights: _____ <input type="checkbox"/> U/K If yes, how old was the infant when admitted to the hospital for the last time? Number of weeks: _____ <input type="checkbox"/> U/K

128. Number of outpatient/ambulatory infant encounters: \_\_\_\_\_. Of these, how many were well child visits? \_\_\_\_\_

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

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

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

Who saw infant	Age in months	Reason for visit	Recommended treatment

**A5. FIMR PARENTAL/CAREGIVER INTERVIEW** A + symbol means that the question is skipped for fetal deaths.

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

The following questions focus on the experience of the biological parents.

130. How does the childbearing parent describe the time just before pregnancy? <input type="radio"/> One of the happiest times of their life <input type="radio"/> A happy time with a few problems <input type="radio"/> A moderately hard time <input type="radio"/> A very hard time <input type="radio"/> One of the worst times of their life <input type="radio"/> U/K	131. How does the childbearing parent remember feeling about becoming pregnant? <input type="radio"/> Wanted to be pregnant sooner <input type="radio"/> Wanted to be pregnant later <input type="radio"/> Wanted to be pregnant then <input type="radio"/> Didn't want to be pregnant then or at any time in the future <input type="radio"/> U/K
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<p>132. Were any of the following identified as psychosocial or lifestyle problems experienced by the childbearing parent AT ANY TIME in their life, as a child, before or during pregnancy?</p> <p><b>Childbearing parent as a child:</b>  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <input type="checkbox"/> Housing unstable/inadequate/homeless <input type="checkbox"/> Food insecurity <input type="checkbox"/> Treated violently <input type="checkbox"/> Parents or caregiver with substance abuse problem <input type="checkbox"/> Parents or caregiver problem drinkers <input type="checkbox"/> Parents or caregiver with mental health problems <input type="checkbox"/> Parental separation or divorce <input type="checkbox"/> Incarcerated household member		<p><b>Current (before or during pregnancy):</b>  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <input type="checkbox"/> Disturbed parent/infant relationship <input type="checkbox"/> Childbearing parent-physical/developmental disability <input type="checkbox"/> Non-childbearing biological parent-physical/developmental disability <input type="checkbox"/> Childbearing parent-employment/education needs <input type="checkbox"/> Non-childbearing biological parent-employment/education needs <input type="checkbox"/> Inadequate support system <input type="checkbox"/> Childbearing or non-childbearing biological parent felt "stereotyped" or profiled due to race, gender, class, etc.	
<p>133. How supportive was the non-childbearing biological parent toward the childbearing parent during the pregnancy?  <input type="radio"/> Not involved <input type="radio"/> Supportive <input type="radio"/> Unsupportive <input type="radio"/> U/K</p>		<p>134. During the childbearing parent's recent pregnancy, did they have others who would have helped if a problem had come up? (For example, needed a ride to the clinic or needed to borrow money.)  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe who would have helped (significant other, friend, in-laws, other family, etc.):</p>	
<p>135. Did the childbearing parent feel that they were ever treated differently or unfairly in getting services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, for what reasons?</p> <input type="checkbox"/> Race <input type="checkbox"/> Type of insurance <input type="checkbox"/> Culture/ethnic background <input type="checkbox"/> Ability to pay <input type="checkbox"/> Citizenship status <input type="checkbox"/> Other, specify: <input type="checkbox"/> Marital status <input type="checkbox"/> U/K		<p>136. Was the childbearing parent currently pregnant at time of parental interview? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, are they currently using birth control?  <input type="radio"/> Yes, describe type of birth control:  <input type="radio"/> No  <input type="radio"/> Trying to get pregnant  <input type="radio"/> U/K</p>	
<p>137. Does the childbearing parent expect to have any more children?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how many? _____ <input type="checkbox"/> U/K</p> <p>When: <input type="checkbox"/> U/K</p>			
<p>138. Did the non-childbearing biological parent experience any stressors during the pregnancy?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s)?</p> <input type="checkbox"/> Work or employment problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Problems with children or other relatives <input type="checkbox"/> Other, specify: <input type="checkbox"/> Problems with drugs or alcohol <input type="checkbox"/> Emotional problems <input type="checkbox"/> Problems with the law <input type="checkbox"/> Money problems <input type="checkbox"/> A death in the family <input type="checkbox"/> Health problems			
<p>The following questions ask about the primary caregiver, who may be the childbearing biological parent or someone else.</p>			
<p>139. Were any of the following identified as psychosocial or lifestyle problems experienced by the caregiver while the infant was still alive?</p> <p><b>Current (after the birth):</b>  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, which one(s):</p> <input type="checkbox"/> Disturbed caregiver/infant relationship <input type="checkbox"/> Caregiver's significant other-employment/education needs <input type="checkbox"/> Caregiver-physical/developmental disability <input type="checkbox"/> Inadequate support system <input type="checkbox"/> Caregiver's significant other-physical/developmental disability <input type="checkbox"/> Caregiver felt "stereotyped" or profiled due to race, gender, class, etc. <input type="checkbox"/> Caregiver-employment/education needs			
<p>140. In the months prior to the infant's death, how often did the caregiver feel that daily activities were overwhelming?  <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Very often  <input type="radio"/> Almost never <input type="radio"/> Fairly often <input type="radio"/> U/K</p>		<p>141. In the months prior to the infant's death, how often did the caregiver say that they felt very sad?  <input type="radio"/> Never <input type="radio"/> Fairly often  <input type="radio"/> Almost never <input type="radio"/> Very often  <input type="radio"/> Sometimes <input type="radio"/> U/K</p>	
<p>142. Did the caregiver feel they had family or friends who could help with the infant at home*?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify who:</p>		<p>143. Did the caregiver feel that their infant was ever treated differently or unfairly in getting services*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, for what reasons?</p> <input type="checkbox"/> Race <input type="checkbox"/> Marital status <input type="checkbox"/> Other, specify: <input type="checkbox"/> Culture/ethnic background <input type="checkbox"/> Type of insurance <input type="checkbox"/> Citizenship status <input type="checkbox"/> Ability to pay <input type="checkbox"/> U/K	

144. How satisfied was the caregiver with the caregiver's significant other's contribution(s) toward their or the infant's financial support? <input type="radio"/> Very satisfied <input type="radio"/> Somewhat satisfied <input type="radio"/> Not satisfied <input type="radio"/> U/K	145. According to the caregiver, did they have a crib, portable crib or bassinet for the infant*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often did the infant sleep in it? <input type="radio"/> Always <input type="radio"/> Usually <input type="radio"/> Half the time <input type="radio"/> Occasionally <input type="radio"/> Never <input type="radio"/> U/K If anything other than "always," describe where else the infant slept:
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146. According to the caregiver, was the infant in the same room with someone who was smoking\*?  
 Yes    No    U/K      If yes, number of hours per day, maximum 24:

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

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

If yes, what were the barriers?

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

**B. BIOLOGICAL PARENT INFORMATION**       No information available, go to Section C

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.

Childbearing Biological Parent (CBP) alive:       Yes    No    U/K

Non-Childbearing Biological Parent (Non-CBP) alive:       Yes    No    U/K

2. Parents' race, check all that apply: <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Alaska Native, Tribe:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> American Indian, Tribe:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Asian, specify:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Black</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Native Hawaiian</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Pacific Islander, specify:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> White</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="checkbox"/>	<input type="checkbox"/> Alaska Native, Tribe:	<input type="checkbox"/>	<input type="checkbox"/> American Indian, Tribe:	<input type="checkbox"/>	<input type="checkbox"/> Asian, specify:	<input type="checkbox"/>	<input type="checkbox"/> Black	<input type="checkbox"/>	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/>	<input type="checkbox"/> Pacific Islander, specify:	<input type="checkbox"/>	<input type="checkbox"/> White	<input type="checkbox"/>	<input type="checkbox"/> U/K	3. Parents' Hispanic or Latino/a origin? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes, specify origin:</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes, specify origin:	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	5. Parents' employment status: <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Employed</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Unemployed</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> On disability</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Stay-at-home</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Retired</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Employed	<input type="radio"/>	<input type="radio"/> Unemployed	<input type="radio"/>	<input type="radio"/> On disability	<input type="radio"/>	<input type="radio"/> Stay-at-home	<input type="radio"/>	<input type="radio"/> Retired	<input type="radio"/>	<input type="radio"/> U/K
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4. Parents' age in years at time of child's death: <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____ # Years</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> </table>		<u>CBP</u>	<u>Non-CBP</u>	_____	_____ # Years	<input type="checkbox"/>	<input type="checkbox"/> U/K	6. Parents' education: <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> &lt; High school</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> High school/GED</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> College</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Post graduate</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> < High school	<input type="radio"/>	<input type="radio"/> High school/GED	<input type="radio"/>	<input type="radio"/> College	<input type="radio"/>	<input type="radio"/> Post graduate	<input type="radio"/>	<input type="radio"/> U/K																						
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7. Parents speak and understand English? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	8. Parents first generation immigrant? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes, country of origin:</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes, country of origin:	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	10. Parents receive social services in the past twelve months? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes    If yes, check all that apply below:</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table> <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> WIC</td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Section 8/housing</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Home visiting, specify:</td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Social Security Disability Insurance (SSI/SSDI)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> TANF</td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Medicaid</td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Food stamps/SNAP/EBT</td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes    If yes, check all that apply below:	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	<u>CBP</u>	<u>Non-CBP</u>	<u>CBP</u>	<u>Non-CBP</u>	<input type="checkbox"/>	<input type="checkbox"/> WIC	<input type="checkbox"/>	<input type="checkbox"/> Section 8/housing	<input type="checkbox"/>	<input type="checkbox"/> Home visiting, specify:	<input type="checkbox"/>	<input type="checkbox"/> Social Security Disability Insurance (SSI/SSDI)	<input type="checkbox"/>	<input type="checkbox"/> TANF	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:	<input type="checkbox"/>	<input type="checkbox"/> Medicaid	<input type="checkbox"/>	<input type="checkbox"/> U/K	<input type="checkbox"/>	<input type="checkbox"/> Food stamps/SNAP/EBT	<input type="checkbox"/>	<input type="checkbox"/> U/K
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11. Parents have substance abuse history? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	12. Parents ever victim of child maltreatment? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	13. Parents ever perpetrator of maltreatment? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	14. Parents have disability or chronic illness? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</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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15. Parents have prior child deaths? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	16. Parents have history of intimate partner violence? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Yes, as victim</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> Yes, as perpetrator</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> No</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</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	17. Parents have delinquent/criminal history? <table style="width:100%; border: none;"> <tr> <th style="text-align: left; border: none;"><u>CBP</u></th> <th style="text-align: left; border: none;"><u>Non-CBP</u></th> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> Yes</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> No</td> </tr> <tr> <td style="border: none;"><input type="radio"/></td> <td style="border: none;"><input type="radio"/> U/K</td> </tr> </table>	<u>CBP</u>	<u>Non-CBP</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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**C. PRIMARY CAREGIVER(S) INFORMATION**

If fetal death, skip to Section D.

1. Primary caregiver(s): Select only one each in columns one and two.						2. Caregiver(s) age in years:																																																				
<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:50px;"></td> <td style="text-align:center"><u>One</u></td> <td style="text-align:center"><u>Two</u></td> <td style="text-align:center"><u>One</u></td> <td style="text-align:center"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td>Self, go to Section D</td> <td></td> <td><input type="radio"/></td> <td>Foster parent</td> <td><input type="radio"/></td> <td>Other relative</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Childbearing parent, go to Section D</td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/> Parent's partner</td> <td><input type="radio"/></td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Non-childbearing biological parent, go to Section D</td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/> Grandparent</td> <td><input type="radio"/></td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Adoptive parent</td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/> Sibling</td> <td><input type="radio"/></td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Stepparent</td> <td></td> <td></td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>			<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	Self, go to Section D		<input type="radio"/>	Foster parent	<input type="radio"/>	Other relative	<input type="radio"/>	<input type="radio"/> Childbearing parent, go to Section D		<input type="radio"/>	<input type="radio"/> Parent's partner	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Non-childbearing biological parent, go to Section D		<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Institutional staff	<input type="radio"/>	<input type="radio"/> Adoptive parent		<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> Stepparent				<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> <td style="width:50px;"></td> <td style="text-align:center"><u>One</u></td> <td style="text-align:center"><u>Two</u></td> </tr> <tr> <td>_____</td> <td>_____</td> <td># Years</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>	_____	_____	# Years	<input type="checkbox"/>	<input type="checkbox"/> U/K		
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4. Caregiver(s) race, check all that apply:						5. Caregiver(s) Hispanic or Latino/a origin?		6. Caregiver(s) employment status:																																																		
<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:50px;"></td> <td style="text-align:center"><u>One</u></td> <td style="text-align:center"><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Alaska Native, Tribe:</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Pacific Islander, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> American Indian, Tribe:</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Asian, specify:</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Black</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Native Hawaiian</td> <td></td> <td></td> <td></td> </tr> </table>			<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/> Alaska Native, Tribe:		<input type="checkbox"/>	<input type="checkbox"/> Pacific Islander, specify:	<input type="checkbox"/>	<input type="checkbox"/> American Indian, Tribe:		<input type="checkbox"/>	<input type="checkbox"/> White	<input type="checkbox"/>	<input type="checkbox"/> Asian, specify:		<input type="checkbox"/>	<input type="checkbox"/> U/K	<input type="checkbox"/>	<input type="checkbox"/> Black				<input type="checkbox"/>	<input type="checkbox"/> Native Hawaiian				<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><input type="radio"/></td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table> If yes, specify origin:		<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><input type="radio"/></td> <td><input type="radio"/> Employed</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> On disability</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Retired</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>		<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/> Employed	<input type="radio"/>	<input type="radio"/> Unemployed	<input type="radio"/>	<input type="radio"/> On disability	<input type="radio"/>	<input type="radio"/> Stay-at-home	<input type="radio"/>	<input type="radio"/> Retired	<input type="radio"/>	<input type="radio"/> U/K
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7. Caregiver(s) education:		8. Do caregiver(s) speak and understand English?		9. Caregiver(s) first generation immigrant?		10. Caregiver(s) on active military duty?																																																				
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11. Caregiver(s) receive social services in the past twelve months?																																																										
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16. Caregiver(s) have prior child deaths?			17. Caregiver(s) have history of intimate partner violence?			18. Caregiver(s) have delinquent/criminal history?																																																				
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**D. SUPERVISOR INFORMATION**

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

1. Did child have supervision at time of incident leading to death?		2. How long before incident did supervisor last see child?	
Select one:		Select one:	
<input type="radio"/> Yes, answer D2-16		<input type="radio"/> Child in sight of supervisor	
<input type="radio"/> No, not needed given developmental age or circumstances, go to Sec. E		<input type="radio"/> Minutes _____ <input type="radio"/> Days _____	
<input type="radio"/> No, but needed, answer D3-16		<input type="radio"/> Hours _____ <input type="radio"/> U/K	
<input type="radio"/> Unable to determine, try to answer D3-16			
3. Is supervisor listed in a previous section?		4. Primary person responsible for supervision at the time of incident? Select only one:	
<input type="radio"/> Yes, childbearing parent, go to D15		<input type="radio"/> Adoptive parent	
<input type="radio"/> Yes, non-childbearing biological parent, go to D15		<input type="radio"/> Sibling	
<input type="radio"/> Yes, caregiver one, go to D15		<input type="radio"/> Other relative	
<input type="radio"/> Yes, caregiver two, go to D15		<input type="radio"/> Institutional staff, go to D15	
<input type="radio"/> No		<input type="radio"/> Stepparent	
		<input type="radio"/> Babysitter	
		<input type="radio"/> Foster parent	
		<input type="radio"/> Friend	
		<input type="radio"/> Licensed child care worker	
		<input type="radio"/> Parent's partner	
		<input type="radio"/> Acquaintance	
		<input type="radio"/> Other, specify:	
		<input type="radio"/> Grandparent	
		<input type="radio"/> Hospital staff, go to D15	
		<input type="radio"/> U/K	

5. Supervisor's age in years: _____ <input type="checkbox"/> U/K	6. Supervisor's sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	7. Supervisor speaks and understands English? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, language spoken:	8. Supervisor on active military duty? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify branch:
9. Supervisor has substance abuse history? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	10. Supervisor has history of child maltreatment? <u>As Victim</u> <u>As Perpetrator</u> <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> U/K	11. Supervisor has disability or chronic illness? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	12. Supervisor has prior child deaths? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
13. Supervisor has history of intimate partner violence? <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	15. At the time of the incident, was the supervisor asleep? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, select the most appropriate description of the supervisor's sleeping period at incident: <input type="radio"/> Night time sleep <input type="radio"/> Day time nap, describe: <input type="radio"/> Day time sleep (for example, supervisor is night shift worker), describe: <input type="radio"/> Other, describe:		16. At time of incident was supervisor impaired? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Drug impaired, specify: <input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Distracted <input type="checkbox"/> Absent <input type="checkbox"/> Impaired by illness, specify: <input type="checkbox"/> Impaired by disability, specify: <input type="checkbox"/> Other, specify:
14. Supervisor has delinquent or criminal history? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

**E. INCIDENT INFORMATION** Answer only E7 if the child never left the hospital following birth

1. Was the date of the incident the same as the date of death? <input type="radio"/> Yes, same as date of death <input type="radio"/> No, different than date of death. Enter date of incident: _____ / _____ / _____ <input type="radio"/> U/K mm / dd / yyyy	2. Approximate time of day that incident occurred? <input type="radio"/> AM Hour, specify 1-12: _____ <input type="radio"/> PM <input type="radio"/> U/K
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3. Place of incident, check all that apply:

<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Military installation	<input type="checkbox"/> State or county park, other recreation area
<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Jail/detention facility	<input type="checkbox"/> Hospital
<input type="checkbox"/> Friend's home	<input type="checkbox"/> Unlicensed child care home	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Licensed foster care home	<input type="checkbox"/> Farm/ranch	<input type="checkbox"/> Roadway	<input type="checkbox"/> U/K
<input type="checkbox"/> Relative foster care home	<input type="checkbox"/> School	<input type="checkbox"/> Driveway	
<input type="checkbox"/> Licensed group home	<input type="checkbox"/> Indian reservation/trust lands	<input type="checkbox"/> Other parking area	

4. Type of area:  Urban  Suburban  Rural  Frontier  U/K

5. Incident state: \_\_\_\_\_ 6. Incident county: \_\_\_\_\_

7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?  
 Yes  No  U/K  
If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:  
If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):

8. Was the incident witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> UK If yes, by whom?	<input type="checkbox"/> Parent/relative <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Other acquaintance	<input type="checkbox"/> Health care professional, if death occurred in a hospital setting <input type="checkbox"/> Stranger <input type="checkbox"/> Other, specify:	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
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10. Was resuscitation attempted? If yes, by whom? <input type="checkbox"/> EMS <input type="checkbox"/> Parent/relative <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Health care professional, if death occurred in a hospital setting <input type="checkbox"/> Stranger <input type="checkbox"/> Other, specify:	<input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 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, including naloxone, specify type: <input type="checkbox"/> Other, specify:	If yes, was a rhythm recorded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, what was the rhythm? _____
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11. At time of incident leading to death, had child used drugs or alcohol? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids <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 _____ Adults <input type="checkbox"/> U/K	

**F. INVESTIGATION INFORMATION**

A + symbol means that the question is skipped for fetal deaths.

1. Was a death investigation conducted\*?  Yes  No  U/K If yes, check all that apply:

Medical examiner  ME investigator  Law enforcement  EMS  Other, specify:

Coroner  Coroner investigator  Fire investigator  Child Protective Services  U/K

If yes, which of the following death investigation components were completed?

<u>Yes</u>	<u>No</u>	<u>U/K</u>			If yes, shared with review team?
<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"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
<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"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
<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"/>	<input type="radio"/>	Witness interviews	<input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>

If yes, was a death scene investigation conducted at the place of incident?  Yes  No  U/K

2. What additional information would the team like to have known about the death scene investigation\*?

3. Death referred to*: <input type="radio"/> Medical examiner <input type="radio"/> Not referred <input type="radio"/> Coroner <input type="radio"/> U/K	4. Person declaring official cause and manner of death*: <input type="radio"/> Medical examiner <input type="radio"/> Hospital physician <input type="radio"/> Mortician <input type="radio"/> U/K <input type="radio"/> Coroner <input type="radio"/> Other physician <input type="radio"/> Other, specify:
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5. Autopsy performed?  Yes  No  U/K

If yes, conducted by:  Forensic pathologist  Unknown type pathologist  Pediatric pathologist  Other physician  General pathologist  Other, specify:  U/K

If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?  Yes  No  U/K If yes, specify specialist: \_\_\_\_\_

If no, why not (e.g. parent or caregiver objected)? \_\_\_\_\_

6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10.

<u>Yes</u>	<u>No</u>	<u>U/K</u>	<u>Yes</u>	<u>No</u>	<u>U/K</u>
<b>Imaging:</b>			<b>External Exam:</b>		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	X-ray - single	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	X-ray - multiple views	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	X-ray - complete skeletal series	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):	<input type="radio"/>	<input type="radio"/>
			<b>Other Autopsy Procedures:</b>	<input type="radio"/>	<input type="radio"/>
			Gross examination of organs done?	<input type="radio"/>	<input type="radio"/>
			Were weights of any organs taken?	<input type="radio"/>	<input type="radio"/>

7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10.

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

8. Was any toxicology testing performed on the child?  Yes  No  U/K

If yes, what were the results?  Negative  Cocaine  Methamphetamine  Too high Rx drug, specify:  Other, specify:

Check all that apply:  Alcohol  Marijuana  Opioids  Too high OTC drug, specify:  U/K

9. Was the child's medical history reviewed as part of the autopsy\*?  Yes  No  U/K

If yes, did this include: Review of the newborn metabolic screen results?  Yes  No  U/K  Not performed

Review of neonatal CCHD screen results?  Yes  No  U/K  Not performed

10. Describe any abnormalities or other significant findings noted in the autopsy\*:

11. What additional information would the team like to have known about the autopsy*?	12. Was there agreement between the cause of death listed on the autopsy report and on the death certificate*? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, describe the differences:
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13. Was a CPS record check conducted as a result of death\*?  Yes  No  U/K

14. Did the child ever have any injuries that were suspicious of child abuse\*?  Yes  No  U/K

If yes, what injuries were found?

Skin injury  Broken bones  Abdominal injury

Mouth injury  Head injury  U/K

Burns

15. Did any investigation find evidence of prior abuse\*?  N/A  Yes  No  U/K

If yes, from what source? Check all that apply:

From x-rays  From law enforcement

From autopsy  U/K

From CPS review

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	17. If death occurred in licensed setting (see E3), indicate action taken*:
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	<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, what services or actions resulted? Check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Court-ordered services provided <input type="checkbox"/> Voluntary out of home placement	<input type="checkbox"/> Court-ordered out of home placement <input type="checkbox"/> Children removed <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: \_\_\_\_\_  U/K

2. Enter the following information exactly as written on the death certificate:  U/K  
 Immediate cause (final disease or condition resulting in death):  
 a. \_\_\_\_\_  
 Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:  
 b. \_\_\_\_\_  
 c. \_\_\_\_\_  
 d. \_\_\_\_\_

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate:  U/K

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

5. Official manner of death from the death certificate:  
 Natural  
 Accident  
 Suicide  
 Homicide  
 Undetermined  
 Pending  
 U/K

6. Primary cause of death: Choose 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.  
 From an external cause of injury. Select one:  
 Motor vehicle and other transport, go to H1  
 Fire, burn, or electrocution, go to H2  
 Drowning, go to H3  
 Asphyxia, go to H4  
 Bodily force or weapon, go to H5  
 Fall or crush, go to H6  
 Poisoning, overdose or acute intoxication, go to H7  
 Undetermined injury, go to I2  
 Other cause, go to H9  
 U/K, go to I2  


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 From a medical cause. Select one and go to H8:  
 Asthma/respiratory, specify: \_\_\_\_\_  
 Cancer, specify: \_\_\_\_\_  
 Cardiovascular, specify: \_\_\_\_\_  
 Congenital anomaly, specify: \_\_\_\_\_  
 COVID-19  
 Diabetes  
 HIV/AIDS  
 Influenza  
 Low birth weight  
 Malnutrition/dehydration  
 Neurological/seizure disorder  
 Pneumonia, specify: \_\_\_\_\_  
 Prematurity  
 SIDS  
 Other infection, specify: \_\_\_\_\_  
 Other perinatal condition, specify: \_\_\_\_\_  
 Other medical condition, specify: \_\_\_\_\_  
 Undetermined medical cause  
 U/K  


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 Undetermined if injury or medical cause, go to I2  
 U/K, go to I2

**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**

a. Vehicles involved in incident:  
 Total number of vehicles: \_\_\_\_\_  

<u>Child's</u>	<u>Other primary vehicle</u>	
<input type="radio"/>	<input type="radio"/>	None
<input type="radio"/>	<input type="radio"/>	Car
<input type="radio"/>	<input type="radio"/>	Van
<input type="radio"/>	<input type="radio"/>	Sport utility vehicle
<input type="radio"/>	<input type="radio"/>	Truck
<input type="radio"/>	<input type="radio"/>	Semi/tractor trailer
<input type="radio"/>	<input type="radio"/>	RV/bus/school bus
<input type="radio"/>	<input type="radio"/>	Motorcycle
<input type="radio"/>	<input type="radio"/>	Tractor/farm vehicle
<input type="radio"/>	<input type="radio"/>	All terrain vehicle
<input type="radio"/>	<input type="radio"/>	Snowmobile
<input type="radio"/>	<input type="radio"/>	Bicycle
<input type="radio"/>	<input type="radio"/>	Train/subway/trolley
<input type="radio"/>	<input type="radio"/>	Other, specify: _____
<input type="radio"/>	<input type="radio"/>	U/K

	<u>Autonomous?</u>			
	N/A	Yes	No	U/K
Child's vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

b. Position of child:  
 Driver  
 Passenger  
 Front seat  
 Back seat  
 Truck bed  
 Other, specify: \_\_\_\_\_  
 U/K  
 On bicycle  
 Pedestrian  
 Walking  
 Boarding/blading  
 Other, specify: \_\_\_\_\_  
 U/K  
 U/K

If passenger, relationship of driver to child:  
 Biological parent  
 Adoptive parent  
 Stepparent  
 Foster parent  
 Parent's partner  
 Grandparent  
 Sibling  
 Other relative  
 Friend  
 Other, specify: \_\_\_\_\_  
 U/K

If bicycle, boarding/blading or other, was the child riding something electric?  
 Yes  No  U/K



<p>c. Did any of the following contribute to the incident? Check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> None listed below</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Driver inexperience</td> </tr> <tr> <td><input type="checkbox"/> Carelessness</td> <td><input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation</td> </tr> <tr> <td><input type="checkbox"/> Racing, not authorized</td> <td><input type="checkbox"/> Driver distraction</td> </tr> <tr> <td><input type="checkbox"/> Drug use</td> <td><input type="checkbox"/> Ran stop sign or red light</td> </tr> <tr> <td><input type="checkbox"/> Alcohol use</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Vehicle ran over child</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Vehicle flipped over</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td></td> </tr> </table>	<input type="checkbox"/> None listed below	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Carelessness	<input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Drug use	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Other driver error, specify:	<input type="checkbox"/> Vehicle ran over child	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Vehicle flipped over	<input type="checkbox"/> U/K	<input type="checkbox"/> Poor weather		<input type="checkbox"/> Poor visibility		<p>d. Location of incident, check all that apply:</p> <input type="checkbox"/> City street <input type="checkbox"/> Residential street <input type="checkbox"/> Rural road <input type="checkbox"/> Highway <input type="checkbox"/> Intersection <input type="checkbox"/> Driveway <input type="checkbox"/> Parking area <input type="checkbox"/> Off road <input type="checkbox"/> RR xing/tracks <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>e. Did driving conditions factor into this incident?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Loose gravel  <input type="checkbox"/> Ice/snow  <input type="checkbox"/> Wet  <input type="checkbox"/> Inadequate lighting  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K       </p>
<input type="checkbox"/> None listed below	<input type="checkbox"/> Poor sight line																									
<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Road hazard																									
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<input type="checkbox"/> Vehicle ran over child	<input type="checkbox"/> Other, specify:																									
<input type="checkbox"/> Vehicle flipped over	<input type="checkbox"/> U/K																									
<input type="checkbox"/> Poor weather																										
<input type="checkbox"/> Poor visibility																										

<p>f. Incident type:</p> <input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle <input type="radio"/> Child in/on a vehicle, struck by the other vehicle <input type="radio"/> Child in/on a vehicle that struck the other vehicle <input type="radio"/> Child in/on a vehicle that struck person/object/ran off the road <input type="radio"/> Other event, specify: <input type="radio"/> U/K	<p>g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc.) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.</p> <input type="radio"/> Child was responsible as driver of vehicle, including single vehicle incidents <input type="radio"/> Driver of child's vehicle was responsible, including single vehicle incidents <input type="radio"/> Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle <input type="radio"/> Multiple drivers were responsible, go to j <input type="radio"/> Unable to determine driver responsible, go to j <input type="radio"/> Other, specify: <input type="radio"/> U/K
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<p>h. Age and license type of driver responsible for incident, check all that apply:</p> <table border="0"> <tr> <td>Age of Driver (if not child)</td> <td>License type/violation:</td> </tr> <tr> <td><input type="radio"/> &lt;16 years</td> <td><input type="checkbox"/> Has no license</td> </tr> <tr> <td><input type="radio"/> 16 to 18 years old</td> <td><input type="checkbox"/> Has a learner's permit</td> </tr> <tr> <td><input type="radio"/> 19 to 21 years old</td> <td><input type="checkbox"/> Has a graduated license</td> </tr> <tr> <td><input type="radio"/> 22 to 29 years old</td> <td><input type="checkbox"/> Has a full license</td> </tr> <tr> <td><input type="radio"/> 30 to 65 years old</td> <td><input type="checkbox"/> Has a full license that has been restricted</td> </tr> <tr> <td><input type="radio"/> &gt;65 years old</td> <td><input type="checkbox"/> Has a suspended license</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/> Was violating graduated licensing rules</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td></td> <td><input type="checkbox"/> U/K</td> </tr> </table>	Age of Driver (if not child)	License type/violation:	<input type="radio"/> <16 years	<input type="checkbox"/> Has no license	<input type="radio"/> 16 to 18 years old	<input type="checkbox"/> Has a learner's permit	<input type="radio"/> 19 to 21 years old	<input type="checkbox"/> Has a graduated license	<input type="radio"/> 22 to 29 years old	<input type="checkbox"/> Has a full license	<input type="radio"/> 30 to 65 years old	<input type="checkbox"/> Has a full license that has been restricted	<input type="radio"/> >65 years old	<input type="checkbox"/> Has a suspended license	<input type="radio"/> U/K	<input type="checkbox"/> Was violating graduated licensing rules		<input type="checkbox"/> Other, specify:		<input type="checkbox"/> U/K	<p>i. Total number of occupants in vehicle responsible for incident: <input type="checkbox"/> N/A          Total number of occupants: _____ <input type="checkbox"/> U/K          Number of teens, ages 14-21: _____ <input type="checkbox"/> U/K</p> <p>j. Was a restraint or safety measure used by the child?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, select the restraint or safety measures used: If yes, describe:  <input type="checkbox"/> Lap/shoulder belt  <input type="checkbox"/> Child seat  <input type="checkbox"/> Belt positioning booster seat  <input type="checkbox"/> Helmet  <input type="checkbox"/> U/K       </p>
Age of Driver (if not child)	License type/violation:																				
<input type="radio"/> <16 years	<input type="checkbox"/> Has no license																				
<input type="radio"/> 16 to 18 years old	<input type="checkbox"/> Has a learner's permit																				
<input type="radio"/> 19 to 21 years old	<input type="checkbox"/> Has a graduated license																				
<input type="radio"/> 22 to 29 years old	<input type="checkbox"/> Has a full license																				
<input type="radio"/> 30 to 65 years old	<input type="checkbox"/> Has a full license that has been restricted																				
<input type="radio"/> >65 years old	<input type="checkbox"/> Has a suspended license																				
<input type="radio"/> U/K	<input type="checkbox"/> Was violating graduated licensing rules																				
	<input type="checkbox"/> Other, specify:																				
	<input type="checkbox"/> U/K																				

**H2. FIRE, BURN, OR ELECTROCUTION**

<p>a. Ignition, heat or electrocution source:</p> <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Hot bath water <input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Other, specify: <input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> U/K <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring	<p>b. Type of incident:</p> <input type="radio"/> Fire, go to c <input type="radio"/> Scald, go to I2 <input type="radio"/> Electrocution, go to o <input type="radio"/> U/K, go to I2	<p>c. Type of building on fire:</p> <input type="radio"/> N/A <input type="radio"/> Trailer/mobile home <input type="radio"/> Single home <input type="radio"/> Row home/townhouse <input type="radio"/> Other, specify: <input type="radio"/> Multi-unit (duplex, apartment, condo) <input type="radio"/> U/K
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<p>d. Fire started by a person?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, person's age:          If yes, did the person have a history of starting fires?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, suspected arson?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>	<p>e. Did any factors delay fire department arrival?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, specify:       </p>	<p>f. Were barriers preventing safe exit?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, check all that apply:  <input type="checkbox"/> Locked/blocked door <input type="checkbox"/> Smoke/fire  <input type="checkbox"/> Window security bars <input type="checkbox"/> Household items/hoarding  <input type="checkbox"/> Locked/blocked window  <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Trapped above first floor <input type="checkbox"/> U/K       </p>
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<p>g. Was the child found in the same location as where the fire started?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>	<p>h. Was building a rental property?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>	<p>i. Were building/rental codes violated?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, describe in narrative.       </p>
<p>j. Were proper working fire extinguishers present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>k. Was fire sprinkler system present?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>	<p>l. Was fire sprinkler system required?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>

<p>m. Were smoke alarms present?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          Were they functioning properly?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>	<p>n. Did the child or family (check all that apply):</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Have two or more possible exits from the location as where the child was found <input type="checkbox"/> U/K <input type="checkbox"/> Have a fire escape plan <input type="checkbox"/> Practice a home fire drill <input type="checkbox"/> Attempt to put out the fire
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<p>o. For electrocution, what cause:</p> <input type="radio"/> Lightning/electrical storm <input type="radio"/> Contact with power line <input type="radio"/> Child playing with outlet <input type="radio"/> U/K <input type="radio"/> Faulty wiring <input type="radio"/> Wire/product in water <input type="radio"/> Other, specify:								
<b>H3. DROWNING</b>								
<p>a. Where was child last seen before drowning? Select one.</p> <input type="radio"/> In water <input type="radio"/> Near water <input type="radio"/> In yard <input type="radio"/> In bathroom/tub <input type="radio"/> In house <input type="radio"/> In car <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>b. Drowning location:</p> <input type="radio"/> Open water/pond, go to c <input type="radio"/> Pool, hot tub, spa, go to f <input type="radio"/> Bathtub, go to I2 <input type="radio"/> Other, specify and go to h  <input type="radio"/> U/K, go to h	<p>c. For open water, place:</p> <input type="radio"/> Lake <input type="radio"/> Ocean <input type="radio"/> River <input type="radio"/> Quarry or gravel pit <input type="radio"/> Pond <input type="radio"/> Canal/drainage ditch <input type="radio"/> Creek <input type="radio"/> U/K  <p>d. Was child boating?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>e. Select all contributing environmental factors. Check all that apply.</p> <input type="checkbox"/> None <input type="checkbox"/> Dropoff <input type="checkbox"/> Weather <input type="checkbox"/> Rough waves <input type="checkbox"/> Temperature <input type="checkbox"/> Flash flood <input type="checkbox"/> Current <input type="checkbox"/> Water clarity <input type="checkbox"/> Riptide/undertow <input type="checkbox"/> U/K					
<p>f. For pool, type of pool:</p> <input type="radio"/> Above-ground <input type="radio"/> In-ground <input type="radio"/> Hot tub, spa <input type="radio"/> Wading <input type="radio"/> U/K	<p>g. For pool, ownership is:</p> <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K	<p>h. Flotation device used at time of the incident?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes, specify: <input type="radio"/> U/K	<p>i. Did the child depend on a life jacket, swim vest or swim aid while in or around water?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K					
<p>j. Did barriers/ayers of protection exist to prevent access to water?      <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Fence  Was it breached?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:  <input type="checkbox"/> Climbed fence  <input type="checkbox"/> Gap in fence  <input type="checkbox"/> Damaged fence  <input type="checkbox"/> Fence too short  Fence surrounds water on:  <input type="radio"/> Four sides   <input type="radio"/> Two or one side  <input type="radio"/> Three sides   <input type="radio"/> U/K </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Gate  Was it breached?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:  <input type="checkbox"/> Gate left open  <input type="checkbox"/> Gate unlocked  <input type="checkbox"/> Gate latch failed  <input type="checkbox"/> Gap in gate </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Door  Was it breached?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:  <input type="checkbox"/> Door left open  <input type="checkbox"/> Door unlocked  <input type="checkbox"/> Door broken  <input type="checkbox"/> Door screen torn  <input type="checkbox"/> Door self-closer failed </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Alarm  Was it breached?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:  <input type="checkbox"/> Alarm not working  <input type="checkbox"/> Alarm not answered </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Cover  Was it breached?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K  If yes, check all that apply:  <input type="checkbox"/> Cover left off  <input type="checkbox"/> Cover not locked </td> </tr> </table>				<input type="checkbox"/> Fence Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Climbed fence <input type="checkbox"/> Gap in fence <input type="checkbox"/> Damaged fence <input type="checkbox"/> Fence too short Fence surrounds water on: <input type="radio"/> Four sides <input type="radio"/> Two or one side <input type="radio"/> Three sides <input type="radio"/> U/K	<input type="checkbox"/> Gate Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Gate left open <input type="checkbox"/> Gate unlocked <input type="checkbox"/> Gate latch failed <input type="checkbox"/> Gap in gate	<input type="checkbox"/> Door Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Door left open <input type="checkbox"/> Door unlocked <input type="checkbox"/> Door broken <input type="checkbox"/> Door screen torn <input type="checkbox"/> Door self-closer failed	<input type="checkbox"/> Alarm Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alarm not working <input type="checkbox"/> Alarm not answered	<input type="checkbox"/> Cover Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Cover left off <input type="checkbox"/> Cover not locked
<input type="checkbox"/> Fence Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Climbed fence <input type="checkbox"/> Gap in fence <input type="checkbox"/> Damaged fence <input type="checkbox"/> Fence too short Fence surrounds water on: <input type="radio"/> Four sides <input type="radio"/> Two or one side <input type="radio"/> Three sides <input type="radio"/> U/K	<input type="checkbox"/> Gate Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Gate left open <input type="checkbox"/> Gate unlocked <input type="checkbox"/> Gate latch failed <input type="checkbox"/> Gap in gate	<input type="checkbox"/> Door Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Door left open <input type="checkbox"/> Door unlocked <input type="checkbox"/> Door broken <input type="checkbox"/> Door screen torn <input type="checkbox"/> Door self-closer failed	<input type="checkbox"/> Alarm Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alarm not working <input type="checkbox"/> Alarm not answered	<input type="checkbox"/> Cover Was it breached? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Cover left off <input type="checkbox"/> Cover not locked				
<p>k. 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>l. Select all of the child's water safety skills (without assistance or flotation device):</p> <input type="checkbox"/> None of these <input type="checkbox"/> Tread water for 1 minute <input type="checkbox"/> Swim 25 yards <input type="checkbox"/> Float on their back independently <input type="checkbox"/> Find a safe exit from the water <input type="checkbox"/> Exit the water <input type="checkbox"/> Step or jump into water over their head <input type="checkbox"/> Control breathing <input type="checkbox"/> Had swimming lessons <input type="checkbox"/> Return to surface <input type="checkbox"/> U/K		<p>m. Child able to swim?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K					
<p>n. 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>o. Lifeguard present?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>p. Rescue attempt made?      <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> If yes, who? Check all that apply:  <input type="checkbox"/> Parent/relative      <input type="checkbox"/> EMS/first responder  <input type="checkbox"/> Other child      <input type="checkbox"/> Bystander  <input type="checkbox"/> Lifeguard      <input type="checkbox"/> Other, specify:  <input type="checkbox"/> Other adult      <input type="checkbox"/> U/K </td> <td style="width:50%; vertical-align: top;"> If yes, did rescuer(s) also drown?  <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> U/K </td> </tr> </table>		If yes, who? Check all that apply: <input type="checkbox"/> Parent/relative <input type="checkbox"/> EMS/first responder <input type="checkbox"/> Other child <input type="checkbox"/> Bystander <input type="checkbox"/> Lifeguard <input type="checkbox"/> Other, specify: <input type="checkbox"/> Other adult <input type="checkbox"/> U/K	If yes, did rescuer(s) also drown? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			
If yes, who? Check all that apply: <input type="checkbox"/> Parent/relative <input type="checkbox"/> EMS/first responder <input type="checkbox"/> Other child <input type="checkbox"/> Bystander <input type="checkbox"/> Lifeguard <input type="checkbox"/> Other, specify: <input type="checkbox"/> Other adult <input type="checkbox"/> U/K	If yes, did rescuer(s) also drown? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K							
<p>q. Appropriate rescue equipment present?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was it used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, describe:								
<b>H4. ASPHYXIA</b>								
<p>a. Type of event:</p> <input type="radio"/> Sleep-related, go to I2 <input type="radio"/> Not sleep-related, go to b <input type="radio"/> U/K, go to b	<p>b. If not sleep-related, was the event:</p> <input type="radio"/> Suffocation, go to c <input type="radio"/> Strangulation, go to d <input type="radio"/> Choking, go to e <input type="radio"/> Other, go to I2	<p>c. If suffocation, was the child:</p> <input type="radio"/> Covered in or fell into object <input type="radio"/> Confined in tight space <input type="radio"/> Wedged into tight space, specify: <input type="radio"/> Other, specify:						
<p>d. If strangulation, object causing event:</p> <input type="radio"/> Clothing <input type="radio"/> Electrical cord <input type="radio"/> Blind cord <input type="radio"/> Person, go to H5I <input type="radio"/> Car seat <input type="radio"/> Automobile power window or sunroof <input type="radio"/> Belt <input type="radio"/> Other, specify: <input type="radio"/> Rope/string <input type="radio"/> Leash <input type="radio"/> U/K	<p>e. If choking, object causing choking:</p> <input type="radio"/> Food, specify: <input type="radio"/> Toy, specify: <input type="radio"/> Vomit/gastric contents <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>f. If choking, was Heimlich Maneuver attempted?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K						

**H5. BODILY FORCE OR WEAPON**

<p>a. Was the death a result of a weapon?</p> <p><input type="radio"/> Yes, go to b</p> <p><input type="radio"/> No, death due to bodily force, go to l</p> <p><input type="radio"/> U/K, go to b</p>	<p>b. Type of weapon:</p> <p><input type="radio"/> Firearm, go to c</p> <p><input type="radio"/> Knife or sharp instrument, go to l</p> <p><input type="radio"/> Rope, go to l</p> <p><input type="radio"/> Other, specify and go to l</p> <p><input type="radio"/> U/K, go to l</p>	<p>c. For firearms, type:</p> <p><input type="radio"/> Handgun</p> <p><input type="radio"/> Shotgun</p> <p><input type="radio"/> Rifle, specify:</p> <p><input type="radio"/> 3D gun</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>e. Was firearm kept loaded?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p> <p>If no, was the ammunition stored locked?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>
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<p>f. Was the firearm kept locked?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>i. Was the person handling the firearm the owner? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Use of weapon at time, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Self injury</td> <td><input type="checkbox"/> Hunting</td> </tr> <tr> <td><input type="checkbox"/> Commission of crime</td> <td><input type="checkbox"/> Target shooting</td> </tr> <tr> <td><input type="checkbox"/> Drug dealing/trading</td> <td><input type="checkbox"/> Playing with weapon</td> </tr> <tr> <td><input type="checkbox"/> Drive-by shooting</td> <td><input type="checkbox"/> Showing gun to others</td> </tr> <tr> <td><input type="checkbox"/> Random violence</td> <td><input type="checkbox"/> Russian roulette</td> </tr> <tr> <td><input type="checkbox"/> Child abuse</td> <td><input type="checkbox"/> Gang-related activity</td> </tr> <tr> <td><input type="checkbox"/> Child was a bystander</td> <td><input type="checkbox"/> Self-defense</td> </tr> <tr> <td><input type="checkbox"/> Argument</td> <td><input type="checkbox"/> Cleaning weapon</td> </tr> <tr> <td><input type="checkbox"/> Jealousy</td> <td><input type="checkbox"/> Loading weapon</td> </tr> <tr> <td><input type="checkbox"/> Intimate partner violence</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Hate crime</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Bullying</td> <td></td> </tr> </table>		<input type="checkbox"/> Self injury	<input type="checkbox"/> Hunting	<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Drug dealing/trading	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Random violence	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Child abuse	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Argument	<input type="checkbox"/> Cleaning weapon	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Hate crime	<input type="checkbox"/> U/K	<input type="checkbox"/> Bullying	
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<input type="checkbox"/> Hate crime	<input type="checkbox"/> U/K																										
<input type="checkbox"/> Bullying																											
<p>g. Did the shooter of the firearm have permission to use the firearm at the time of incident?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>j. Owner of fatal firearm:</p> <p><input type="radio"/> Caregiver</p> <p><input type="radio"/> Other family member</p> <p><input type="radio"/> Child's significant other</p> <p><input type="radio"/> Friend/acquaintance</p> <p><input type="radio"/> Stranger</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>																										
<p>h. Did the caregiver or supervisor know a firearm was present at the time of incident?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>k. Was the firearm stolen?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>																										

m. Type of bodily force used. Check all that apply:

<input type="checkbox"/> Beat, kick or punch	<input type="checkbox"/> Bite	<input type="checkbox"/> Throw	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Drop	<input type="checkbox"/> Shake	<input type="checkbox"/> Drown	
<input type="checkbox"/> Push	<input type="checkbox"/> Strangle/choke	<input type="checkbox"/> Burn	<input type="checkbox"/> U/K

**H6. FALL OR CRUSH**

<p>a. Type:</p> <p><input type="radio"/> Fall, go to b</p> <p><input type="radio"/> Crush, go to g</p>	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <p><input type="checkbox"/> U/K</p>	<p>c. Child fell from:</p> <table border="0"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td><input type="radio"/> U/K</td> </tr> </table>				<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:	<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:	<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass		<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	<input type="radio"/> U/K
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<p>d. Surface child fell onto:</p> <p><input type="radio"/> Cement/concrete</p> <p><input type="radio"/> Grass</p> <p><input type="radio"/> Gravel</p> <p><input type="radio"/> Wood floor</p> <p><input type="radio"/> Carpeted floor</p> <p><input type="radio"/> Linoleum/vinyl</p> <p><input type="radio"/> Marble/tile</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Barrier in place, check all that apply::</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Screen</p> <p><input type="checkbox"/> Other window guard</p> <p><input type="checkbox"/> Fence</p> <p><input type="checkbox"/> Railing</p> <p><input type="checkbox"/> Stairway</p> <p><input type="checkbox"/> Gate</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>g. For crush, did child:</p> <p><input type="radio"/> Climb up on object</p> <p><input type="radio"/> Pull object down</p> <p><input type="radio"/> Hide behind object</p> <p><input type="radio"/> Go behind object</p> <p><input type="radio"/> Fall out of object</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>h. For crush, object causing crush:</p> <p><input type="radio"/> Appliance</p> <p><input type="radio"/> Television</p> <p><input type="radio"/> Furniture</p> <p><input type="radio"/> Walls</p> <p><input type="radio"/> Playground equipment</p> <p><input type="radio"/> Animal</p> <p><input type="radio"/> Tree branch</p> <p><input type="radio"/> Boulders/rocks</p> <p><input type="radio"/> Dirt/sand</p> <p><input type="radio"/> Person, go to H5l</p> <p><input type="radio"/> Commercial</p> <p><input type="radio"/> Farm equipment</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>
<p>f. Was child pushed, dropped or thrown?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, go to H5l</p>			

## H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Source of Substance	5 = Own prescription (Prescription only)	Stored in locked cabinet?	How substance was <b>taken</b>
1 = Bought from dealer or stranger (Prescription or illicit only)	6 = Bought from store/pharmacy (OTC or other substances only)	Yes	1 = In utero      5 = Through skin
2 = Bought from friend or relative	7 = Other	No	2 = Orally        9 = U/K
3 = From friend or relative for free	9 = U/K	U/K	3 = Nasally
4 = Took from friend or relative without asking			4 = Intravenously

Prescription drug	Source	Stored	Taken	Over-the-counter drug	Source	Stored	Taken
<input type="checkbox"/> Antidepressant/antianxiety		Y	N U	<input type="checkbox"/> Antihistamine		Y	N U
<input type="checkbox"/> Anticonvulsant		Y	N U	<input type="checkbox"/> Cold medicine		Y	N U
<input type="checkbox"/> Antipsychotic		Y	N U	<input type="checkbox"/> Pain medication		Y	N U
<input type="checkbox"/> Benzodiazepines		Y	N U	<input type="checkbox"/> Other OTC, specify:		Y	N U
<input type="checkbox"/> Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)		Y	N U				
<input type="checkbox"/> Non-opioid pain medication		Y	N U				
<input type="checkbox"/> Opioid pain medication (including fentanyl)		Y	N U				
<input type="checkbox"/> Stimulants		Y	N U				
<input type="checkbox"/> Other Rx, specify:		Y	N U				

Was it child's prescription?     Yes    No    U/K

Illicit drugs	Source	Stored	Taken	Other substances	Source	Stored	Taken
<input type="checkbox"/> Cocaine		Y	N U	<input type="checkbox"/> Alcohol		Y	N U
<input type="checkbox"/> Heroin		Y	N U	<input type="checkbox"/> Battery		Y	N U
<input type="checkbox"/> Illicitly manufactured fentanyl/fentanyl analogs		Y	N U	<input type="checkbox"/> Carbon monoxide		Y	N U
<input type="checkbox"/> Marijuana/THC		Y	N U	<input type="checkbox"/> Other fume/gas/vapor		Y	N U
<input type="checkbox"/> Methamphetamine		Y	N U	<input type="checkbox"/> Other, specify:		Y	N U
<input type="checkbox"/> Other, specify:		Y	N U				

<p>b. Was the incident the result of?</p> <input type="radio"/> Accidental overdose/acute intoxication <input type="radio"/> Medical treatment mishap <input type="radio"/> Deliberate poisoning <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Did the child have a prescription for a controlled substance within the previous 24 months?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Did child have a non-fatal overdose within the previous 12 months?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>e. Was Poison Control contacted?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>f. For CO poisoning, was a CO alarm present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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## H8. MEDICAL CONDITION This section is skipped for fetal deaths\*

<p>a. How long did the child have the medical condition?</p> <input type="radio"/> In utero <input type="radio"/> 1-11 months <input type="radio"/> Since birth <input type="radio"/> >= 1 year <input type="radio"/> < 1 day <input type="radio"/> 1-6 days <input type="radio"/> U/K <input type="radio"/> 7-30 Days	<p>b. Was the death expected as a result of the medical condition?</p> <input type="checkbox"/> N/A, not previously diagnosed <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> But at a later date	<p>c. Was child receiving health care for the medical condition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, within 48 hours of the death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, was the care plan appropriate for the medical condition?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If no, specify:</p>
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<p>d. Did the family experience barriers that prohibited following the care plan?</p> <input type="radio"/> N/A    If yes, what treatment components were not completed? Check all that apply. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Appointments <input type="checkbox"/> Other, specify: <input type="checkbox"/> Medications, specify: <input type="checkbox"/> U/K <input type="checkbox"/> Medical equipment use, specify: <input type="checkbox"/> Therapies, specify:
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<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>If yes, was the child vaccinated?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>g. Was the death potentially caused by a medical error?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment?</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**

**12. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:**

Yes, go to I2a     No, go to I2t     U/K, go to I2a

**WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT\*?**

<p>a. Incident sleep place:</p> <table style="width:100%; border:none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Crib                      If crib, type:  <input type="radio"/> Not portable  <input type="radio"/> Portable  <input type="radio"/> Unknown crib type  <input type="radio"/> Bassinet  <input type="radio"/> Bed side sleeper  <input type="radio"/> Baby box                 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Adult bed  <input type="radio"/> Waterbed  <input type="radio"/> Futon  <input type="radio"/> Couch  <input type="radio"/> Chair  <input type="radio"/> Floor  <input type="radio"/> Car seat                 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Rocking-inclined sleeper  <input type="radio"/> Stroller  <input type="radio"/> Swing  <input type="radio"/> Bouncy chair  <input type="radio"/> Other, specify:  <input type="radio"/> U/K                 </td> <td style="width:33%; vertical-align: top;">                     If adult bed, what type?  <input type="radio"/> Twin  <input type="radio"/> Full  <input type="radio"/> Queen  <input type="radio"/> King  <input type="radio"/> Other, specify:  <input type="radio"/> U/K                 </td> <td style="width:33%; vertical-align: top;">                     If car seat, was car seat secured in seat of car?  <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K                 </td> </tr> </table>				<input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box	<input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat	<input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K	If car seat, was car seat secured in seat of car? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box	<input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat	<input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K	If car seat, was car seat secured in seat of car? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
<p>b. Child put to sleep:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>c. Child found:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>e. Usual sleep position:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>f. Was there any type of crib, portable crib or bassinet in home for child?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K					
<p>d. Usual sleep place:</p> <table style="width:100%; border:none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Crib                      If crib, type:  <input type="radio"/> Not portable  <input type="radio"/> Portable  <input type="radio"/> Unknown crib type  <input type="radio"/> Bassinet  <input type="radio"/> Bed side sleeper  <input type="radio"/> Baby box                 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Adult bed  <input type="radio"/> Waterbed  <input type="radio"/> Futon  <input type="radio"/> Couch  <input type="radio"/> Chair  <input type="radio"/> Floor  <input type="radio"/> Car seat                 </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> Rocking-inclined sleeper  <input type="radio"/> Stroller  <input type="radio"/> Swing  <input type="radio"/> Bouncy chair  <input type="radio"/> Other, specify:  <input type="radio"/> U/K                 </td> <td style="width:33%; vertical-align: top;">                     If adult bed, what type?  <input type="radio"/> Twin    <input type="radio"/> King  <input type="radio"/> Full    <input type="radio"/> Other, specify:  <input type="radio"/> Queen   <input type="radio"/> U/K                 </td> </tr> </table>				<input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box	<input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat	<input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> King <input type="radio"/> Full <input type="radio"/> Other, specify: <input type="radio"/> Queen <input type="radio"/> U/K	
<input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable <input type="radio"/> Unknown crib type <input type="radio"/> Bassinet <input type="radio"/> Bed side sleeper <input type="radio"/> Baby box	<input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat	<input type="radio"/> Rocking-inclined sleeper <input type="radio"/> Stroller <input type="radio"/> Swing <input type="radio"/> Bouncy chair <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> King <input type="radio"/> Full <input type="radio"/> Other, specify: <input type="radio"/> Queen <input type="radio"/> U/K					
<p>g. Child in a new or different environment than usual?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe why:	<p>h. Child last placed to sleep with a pacifier?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>i. Child wrapped or swaddled in blanket when last placed?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:						
<p>j. Child overheated?    <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> Check all that apply: <input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing		<p>k. Child exposed to second hand smoke?</p> <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>l. Child's face when found:</p> <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	<p>m. Child's neck when found:</p> <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> Turned <input type="radio"/> U/K	<p>n. Child's airway when found (includes nose, mouth, neck and/or chest):</p> <input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K	<p>If fully or partially obstructed, what was obstructed?</p> <input type="checkbox"/> Nose <input type="checkbox"/> Chest compressed <input type="checkbox"/> Mouth <input type="checkbox"/> U/K <input type="checkbox"/> Neck compressed If fully or partially obstructed, describe obstruction in detail:					

o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	Present?		If present, describe position of object:					If present, did object obstruct airway?				
	Yes	No	U/K	On top of child	Under child	Next to child	Tangled around child	U/K	Yes	No		UK
	Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>		<input type="radio"/>
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fitted sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Nursing or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bottle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Wearable monitor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other(s), specify:	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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

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

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

s. 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: \_\_\_\_\_

U/K

t. Is there a scene re-creation photo available for upload?  Yes  No If yes, upload here. Only one photo allowed.  
 Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

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

a. Describe product and circumstances:

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 <input type="radio"/> U/K If no, go to <a href="http://www.saferproducts.gov">www.saferproducts.gov</a> to report
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**14. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME\*?**  Yes  No, go to I5  U/K, go to I5

a. Type of crime, check all that apply:

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

**15. 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 15b  <input type="radio"/> Child neglect, go to 15f  <input type="radio"/> Poor/absent supervision, go to 15h  <input type="radio"/> Exposure to hazards, go to 15g</p>	<p>b. Type of child abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to 15c  <input type="checkbox"/> Chronic Battered Child Syndrome, go to 15e  <input type="checkbox"/> Beating/kicking, go to 15e  <input type="checkbox"/> Scalding or burning, go to 15e  <input type="checkbox"/> Munchausen Syndrome by Proxy, go to 15e  <input type="checkbox"/> Sexual assault, go to 15h  <input type="checkbox"/> Other, specify and go to 15h  <input type="checkbox"/> U/K, go to 15e</p>	<p>c. For abusive head trauma, were there retinal hemorrhages?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>d. For abusive head trauma, was the child shaken?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was there impact?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
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<p>e. Events(s) triggering child abuse. check all that apply:</p> <p><input type="checkbox"/> None  <input type="checkbox"/> Crying  <input type="checkbox"/> Toilet training  <input type="checkbox"/> Disobedience  <input type="checkbox"/> Feeding problems  <input type="checkbox"/> Domestic argument  <input type="checkbox"/> Other, specify:  <input type="checkbox"/> U/K</p>	<p>f. Child neglect, check all that apply:</p> <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 surface 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 surface 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.</p> <p><input type="radio"/> Hazard(s) in sleep environment (including sleep position and surface 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"/> Childbearing parent substance use during pregnancy  <input type="radio"/> Other hazard, specify:</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 surface 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:			

h. Was poverty a factor?  Yes  No  U/K If yes, explain in Narrative

**17. LIFE STRESSORS** Please indicate all stressors that were present for this child and family around the time of death.

a. Life stressors - Social/economic

<input type="checkbox"/> None listed below	<input type="checkbox"/> Neighborhood discord	<input type="checkbox"/> No phone	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Lack of child care
<input type="checkbox"/> Racism	<input type="checkbox"/> Job problems	<input type="checkbox"/> Housing instability	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Discrimination	<input type="checkbox"/> Money problems	<input type="checkbox"/> Witnessed violence	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Pregnancy scare
<input type="checkbox"/> Poverty	<input type="checkbox"/> Food insecurity	<input type="checkbox"/> Tobacco exposure		

b. Life stressors - Medical

<input type="checkbox"/> None listed below	<input type="checkbox"/> Caregiver unskilled in providing care	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Felt dismissed by provider
<input type="checkbox"/> Lack of family or social support for care	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Limitations of health insurance	<input type="checkbox"/> Lack of provider-family compatibility
<input type="checkbox"/> Caregiver distrust of health care system	<input type="checkbox"/> Services not available	<input type="checkbox"/> Provider bias	

c. Life Stressors- Relationships

<input type="checkbox"/> None listed below	<input type="checkbox"/> Parents' incarceration	<input type="checkbox"/> Argument with friends	<input type="checkbox"/> Cyberbullying as victim	<input type="checkbox"/> Stress due to gender identity
<input type="checkbox"/> Family discord	<input type="checkbox"/> Breakup	<input type="checkbox"/> Isolation	<input type="checkbox"/> Cyberbullying as a perpetrator	
<input type="checkbox"/> Argument w/ parents/caregivers	<input type="checkbox"/> Argument with significant other	<input type="checkbox"/> Bullying as victim	<input type="checkbox"/> Peer violence as a victim	<input type="checkbox"/> Stress due to sexual orientation
<input type="checkbox"/> Parents' divorce/separation	<input type="checkbox"/> Social discord	<input type="checkbox"/> Bullying as perpetrator	<input type="checkbox"/> Peer violence as a perpetrator	

h. Life stressors - Describe any other life stressors:

**18. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)**

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:

<input type="checkbox"/> None listed below	<input type="checkbox"/> Mental health or substance use/abuse care
<input type="checkbox"/> School	<input type="checkbox"/> Home-based services (non-child welfare)
<input type="checkbox"/> Daycare	<input type="checkbox"/> Child welfare services
<input type="checkbox"/> Employment	<input type="checkbox"/> Legal proceedings within criminal, civil, or family courts
<input type="checkbox"/> Social services (like unemployment assistance, TANF, WIC)	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Living environment	
<input type="checkbox"/> Medical care	<input type="checkbox"/> U/K

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?  Yes  No  U/K  
 If yes, was the stay at home order in place at the time of the child's death?  Yes  No  U/K

c. Was the child exposed to COVID-19 within 14 days of death?  Yes  No  U/K If yes, describe:

d. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death?  Yes  No  U/K  
 If yes, was the child diagnosed with MIS-C?  Yes  No  U/K

<p>e. Was the child eligible to receive a COVID-19 vaccination? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If eligible, did they receive their first dose? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, approx. number of weeks before death: ____</p> <p>If eligible and received their first dose, which option best represents their vaccination status? <input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K</p>	
<p>f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, when did they receive their first dose?</p> <p><input type="radio"/> Before pregnancy <input type="radio"/> 3rd trimester</p> <p><input type="radio"/> 1st trimester <input type="radio"/> After delivery</p> <p><input type="radio"/> 2nd trimester <input type="radio"/> U/K</p> <p>If yes, which option best represents their vaccination status? <input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K</p>	
<p>g. Select the one option that best describes the impact of COVID-19 on this child's death:</p> <p><input type="radio"/> COVID-19 was the immediate or underlying cause of death</p> <p><input type="radio"/> COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19</p> <p><input type="radio"/> COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death</p> <p><input type="radio"/> The childbearing parent contracted COVID-19, specify:</p> <p><input type="radio"/> Before pregnancy <input type="radio"/> 3rd trimester</p> <p><input type="radio"/> 1st trimester <input type="radio"/> After delivery</p> <p><input type="radio"/> 2nd trimester <input type="radio"/> U/K</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> COVID-19 had no impact on this child's death</p> <p><input type="radio"/> U/K</p>	<p>h. Did COVID-19 impact the team's ability to conduct this fatality review?</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"/> Unable to obtain records</p> <p><input type="checkbox"/> Team members unable to attend review</p> <p><input type="checkbox"/> Remote reviews negatively impacted review process</p> <p><input type="checkbox"/> Team leaders redirected to COVID-19 response</p>

**J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)** This section is skipped for fetal deaths\*

<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 K</p> <p><input type="radio"/> U/K, go to K</p>	<p>2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>3. Did the team have information about the person(s)?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																														
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<p>4. Is person listed in a previous section?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </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"/>	<p>5. Primary person(s) responsible for action(s): Select one for each person responsible.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>		<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<p>6. Person's age in years:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td>____</td> <td>____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	____	____	<input type="checkbox"/>	<input type="checkbox"/>	<p>7. Person's sex:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>8. Person speaks and understands English?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>9. Person on active military duty?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																									
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<p>10. Person(s) have history of substance abuse?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>11. Person(s) have history of child maltreatment as victim?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>13. Person(s) have disability or chronic illness?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																							
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<p>14. Person(s) have prior child deaths?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>15. Person(s) have history of intimate partner violence?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>16. Person(s) have delinquent/criminal history?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																														
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17. At the time of the incident, was the person asleep? One Two

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

<p>18. At time of incident was person impaired?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <span style="margin-left: 100px;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p>If yes, check all that apply:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"><u>One</u> <u>Two</u></td> <td style="width: 35%;"><u>One</u> <u>Two</u></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Drug impaired, specify: <input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Alcohol impaired</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Distracted <input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Absent <input type="checkbox"/> <input type="checkbox"/> Other, specify:</td> </tr> </table>	<u>One</u> <u>Two</u>	<u>One</u> <u>Two</u>	<input type="checkbox"/> <input type="checkbox"/>	Drug impaired, specify: <input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:	<input type="checkbox"/> <input type="checkbox"/>	Alcohol impaired	<input type="checkbox"/> <input type="checkbox"/>	Distracted <input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:	<input type="checkbox"/> <input type="checkbox"/>	Absent <input type="checkbox"/> <input type="checkbox"/> Other, specify:	<p>19. Person(s) have, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions</p>	<p>20. Legal outcomes in this death, check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
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<input type="checkbox"/> <input type="checkbox"/>	Distracted <input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:											
<input type="checkbox"/> <input type="checkbox"/>	Absent <input type="checkbox"/> <input type="checkbox"/> Other, specify:											

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

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

If yes, select one option per row:

	<u>before review</u>	<u>referral</u>	<u>not available</u>	<u>N/A</u>	<u>U/K</u>
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Debriefing for professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genetic counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home visiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**L. FINDINGS IDENTIFIED DURING THE REVIEW**  Mark this case to edit/add findings at a later date

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

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

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

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

If yes, select all that apply and describe:

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

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



**M. THE REVIEW MEETING PROCESS**

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

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

5. Were the following data sources available at the review meeting?  
Check all that apply:

**Vital statistics**

- Birth certificate - full form
- Death certificate

**Health records**

- Child's medical records or clinical history, including vaccination
- Hospital records
- Childbearing parent's obstetric and prenatal information
- Newborn screening results
- Mental health records
- Substance abuse treatment records

**Investigation records**

- Autopsy/pathology reports
- CDC's SUIDI Reporting Form
- Jurisdictional equivalent of the CDC SUIDI Reporting Form
- Law enforcement records
- Social service records
- Child protection agency records
- EMS run sheet

**Other**

- Home visiting
- School records

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

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

7. Review meeting outcomes, check all that apply:

- Team disagreed with official manner of death. What did team believe manner should be? \_\_\_\_\_
- Team disagreed with official cause of death. What did team believe cause should be? \_\_\_\_\_
- Because of the review, the official cause or manner of death was changed

**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><b>1. Pre-/Inter-/Post-conception Care</b></p> <p>Y N U Preconception care</p> <p>Y N U Postpartum visit kept</p> <p>Y N U Pregnancy planning/BC education  <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After</p> <p>Y N U Dental/oral care  <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After</p> <p>Y N U Chronic disease control education  <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After</p> <p>Y N U Weight mgmt/dietitian  <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After</p> <p>Y N U Bereavement referral</p> <p><b>2. Medical: Childbearing parent (CBP)</b></p> <p>P C Early teen (17 and under) pregnancy</p> <p>P C Late teen (18 &amp; 19) pregnancy</p> <p>P C Pregnancy &gt;35 yrs</p> <p>P C Cord problem</p> <p>P C Placental abruption</p> <p>P C Placenta Previa</p> <p>P C Chorioamnionitis</p> <p>P C Pre-existing diabetes</p> <p>P C Gestational diabetes</p> <p>P C Cervical insufficiency</p> <p>P C Previous abnormal PAP</p> <p>P C Infection: BV</p> <p>P C Infection: Group B Strep</p> <p>P C Infection: Urinary tract infection</p> <p>P C STI - _____</p> <p>P C Other source of infection: _____</p> <p>P C Multiple gestation #</p> <p>P C Weight: BMI:</p> <p>P C Insufficient/excess weight gain</p> <p>P C Poor nutrition</p> <p>P C Pre-existing hypertension</p> <p>P C Preeclampsia</p> <p>P C Eclampsia</p> <p>P C Preterm labor</p> <p>P C Pregnancy &lt;18 m apart</p> <p>P C PROM</p> <p>P C PPROM</p> <p>P C Prolonged Rupture of Membrane</p> <p>P C Pre-existing dental/oral issues</p> <p>P C Oligo-/Polyhydramnios</p> <p>P C Previous SABs or miscarriages#</p> <p>P C Previous Therapeutic ab # /Vol ab #</p> <p>P C Previous fetal loss #</p> <p>P C Previous infant loss # _____</p> <p>P C Previous LBW delivery</p> <p>P C Previous preterm delivery</p> <p>P C VBAC this pregnancy</p> <p>P C Previous C-Section: #</p> <p>P C C-Section this pregnancy</p> <p>P C Previous ectopic pregnancy</p> <p>P C First pregnancy &lt;18 yrs old</p> <p>P C &gt;4 Live births</p> <p>P C Assist reprod tech:</p> <p>P C Other, specify:</p>	<p><b>3. Family Planning</b></p> <p>P C Intended pregnancy</p> <p>P C Unintended pregnancy</p> <p>P C Unwanted pregnancy</p> <p>P C No birth control</p> <p>P C Failed contraceptive</p> <p>P C Lack of knowledge: methods</p> <p>P C Lack of resources</p> <p>P C Other, specify:</p> <p><b>4. Substance Use</b></p> <p>P C Positive drug test</p> <p>P C No drug test</p> <p>P C Tobacco use: hx, not current</p> <p>P C Tobacco use: current</p> <p>P C Alcohol use: hx, not current</p> <p>P C Alcohol use: current</p> <p>P C Illicit drug use:hx, not current</p> <p>P C Illicit drugs: current: type: _____</p> <p>P C Use of un-pres meds: type: _____</p> <p>P C OTC/Rx meds: type: _____</p> <p>P C Other, specify:</p> <p><b>5. Prenatal Care/Delivery</b></p> <p>P C Standard of care not met</p> <p>P C Inadequate assessment</p> <p>P C No prenatal care</p> <p>P C Late entry to prenatal care</p> <p>P C Lack of progesterone therapy</p> <p>P C Lack of referrals</p> <p>P C Missed appointments</p> <p>P C Multiple providers/sites</p> <p>P C Lack of dental assessment</p> <p>P C Lack of dental care</p> <p>P C Inappropriate use of ER</p> <p>P C Other, specify:</p> <p><b>6. Medical: Fetal/Infant</b></p> <p>P C Non-viable fetus</p> <p>P C LBW (&lt;2500 grams)</p> <p>P C VLBW (&lt;1500 grams)</p> <p>P C ELBW (&lt;750 grams)</p> <p>P C Intrauterine Growth Restriction</p> <p>P C Congenital anomaly</p> <p>P C Prematurity</p> <p>P C Infection/sepsis</p> <p>P C Failure to thrive</p> <p>P C Birth injury</p> <p>P C Feeding problem</p> <p>P C Respiratory Distress Syndrome</p> <p>P C Developmental delay</p> <p>P C Inappropriate level of care</p> <p>P C Positive drug test</p> <p>P C Other, specify:</p> <p><b>7. Pediatric Care</b></p> <p>P C Standard of care not met</p> <p>P C Inadequate assessment</p> <p>P C No pediatric care</p> <p>P C Lack of referrals</p> <p>P C Missed aptmnt/immunizations</p>	<p><b>7. Pediatric Care (Continued)</b></p> <p>P C Multiple providers/sites</p> <p>P C Inappropriate use of ER</p> <p>P C Other, specify:</p> <p><b>8. Environment</b></p> <p>P C Unsafe neighborhood</p> <p>P C Substandard housing</p> <p>P C Overcrowding</p> <p>P C Second-hand smoke</p> <p>P C Little/no breastfeeding</p> <p>P C Improper formula prep/feeding</p> <p>P C Improper/no car seat use</p> <p>P C Unsafe sleep location</p> <p>P C Objects in sleep environment</p> <p>P C Infant overheating</p> <p>P C Not back sleep position</p> <p>P C Apnea monitor, misuse</p> <p>P C Lack of adult supervision</p> <p>P C Other, specify:</p> <p><b>9. Injuries</b></p> <p>P C Suffocation/strangulation</p> <p>P C Abusive head trauma</p> <p>P C General trauma</p> <p>P C Other, specify:</p> <p><b>10. Social Support</b></p> <p>P C Lack of family support</p> <p>P C Lack of neighbors/ community support</p> <p>P C Lack of partner support</p> <p>P C Single parent</p> <p>P C Living alone</p> <p>P C &lt;12th grade education</p> <p>P C Special education</p> <p>P C Physical/cognitive disability</p> <p>P C Other, specify:</p> <p><b>11. Partner/Caregiver</b></p> <p>P C Employment <input type="radio"/> Yes <input type="radio"/> No</p> <p>P C Hx of mental illness</p> <p>P C Substance or tobacco use/abuse: hx specify:</p> <p>P C Substance or tobacco use/abuse: current specify:</p> <p>P C Other, specify:</p> <p><b>12. Family Transition</b></p> <p>P C Frequent/recent moves</p> <p>P C Living in shelter/homeless</p> <p>P C Concern re: citizenship</p> <p>P C Divorce/separation</p> <p>P C Multiple partners</p> <p>P C Prison/parole/probation (CBP)</p> <p>P C Prison/parole/probation (Non-CBP)</p> <p>P C Major illness/death in family</p> <p>P C Other, specify:</p>
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**13. Mental Health/Stress**

- P C Hx of mental illness (CBP)
- P C Depression/anxiety/mental illness during pregnancy
- P C Depression/anxiety/mental illness in postpartum period
- P C Multiple stresses
- P C Social chaos
- P C Employment  Yes  No
- P C Concern about enough money
- P C Work/employment problems
- P C Child(ren) with special needs
- P C Problems with family/relatives
- P C Lack of grief support
- P C Other, specify:

**14. Family Violence/Neglect**

- Childbearing parent:
- P C Hx of abuse (CBP), specify:
- P C Current abuse (CBP), specify:
- Non-childbearing biological parent:
- P C Hx of abuse (Non-CBP), specify:
- P C Current abuse (Non-CBP), specify:
- P C Hx child abuse: this infant
- P C Hx child abuse: other child
- P C Current child abuse: this infant
- P C Current child abuse: other child
- P C Hx child neglect: this infant
- P C Hx child neglect: other child
- P C Current child neglect: this infant
- P C Current child neglect: other child
- P C CPS referrals
- P C Police reports
- P C Other, specify:

**15. Culture**

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

**16. Payment for Care**

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

**17. Services Provided**

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

**18. Transportation**

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

**19. Documentation**

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

**20. Other**

- P C Other, specify:

**P. FORM COMPLETED BY:**

Person:

Email:

Title:

Date completed:

Agency:

Data entry completed for this case?

Phone:

For State Program Use Only:

Data quality assurance completed by state?



Center for Fatality Review & Prevention

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Data Entry: <https://data.ncfrp.org>

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