Arizona Infant Death Investigation Checklist

Scene Investigated by _____Agency _____Phone Number _____ County _____

A. General Information

1. Infant's name _____; Sex _____; Age _____; Date of birth _____
2. Date of death _____; Time of death _____AM/PM; Location _____
3. Father's name _____; Age _____; Occupation _____
4. Mother's name _____; Age _____; Occupation _____
5. Are there siblings? ☐ Yes, ☐ No; If yes, list ages _____
6. Home address (if different from location of death) _____
7. Pediatrician (family physician) _____ Physician's Phone _____

B. Past History

8. Birth weight _____lbs _____oz; Was infant premature? ☐ Yes, ☐ No; If yes, number of weeks premature: _____
9. Place of Birth (Hospital and City/State) _____
10. Any problems with pregnancy and delivery? ☐ Yes, ☐ No; If yes, explain:_____
11. During pregnancy, did anyone: ☐ Smoke? Who? _____; ☐ Use drugs? Who? _____What? _____
12. Has infant ever required hospitalization or emergency care? ☐ Yes, ☐ No; If yes, explain: When? _____
    Where?_____,
    Why?_____
13. Anything unusual about sleeping habits or breathing? ☐ Yes, ☐ No; Has infant turned blue or stopped breathing? ☐ Yes, ☐ No;
    Has infant had seizures or convulsions? ☐ Yes, ☐ No; If yes, explain: _____
14. Any other medical problems or concerns? ☐ Yes, ☐ No; If yes, explain: _____
15. Has infant been immunized? ☐ Yes, ☐ No; If yes, are immunizations up to date? ☐ Yes, ☐ No, ☐ Unk; Date of last immunization: _____
16. Have there been other child deaths in this family or relatives of the immediate family? ☐ Yes, ☐ No; If yes, where? _____
    Cause of death(s)_____;
    Age(s) at death: _____

C. History

17. Was infant: □ Breast-fed □ Bottle-fed □ Both; Last feeding _____AM/PM; What was last feeding? _____
18. Recent illness? □ Yes, □ No; If yes, what? □ Appetite change, □ Cough, □ Diarrhea, □ Ear infection, □ Fever, □ Irritability/listlessness,
□ Sniffles, □ Vomiting, □ Weakness/ "floppiness", □ Wheezing, □ Other
_____
Were medications or home remedies given? □ Yes, □ No; If yes, what?_____*; Amount_____; Time _____ AM/PM
19. Was there recent exposure to chemicals? □ Yes, □ No; If yes, what?
_____; When _____
20. Is anybody in the house sick? □ Yes, □ No; If yes, who? _____; Illness_____
21. Was there a history of a recent fall or injury? □ Yes, □ No; If yes, explain:
_____
22. Was the infant in anyone else's care in the last 48 hours? □ Yes, □ No; If so, whom?
_____
23. Last date infant was seen by a medical provider: _____; Where?_____; Reason for visit: _____

D. Scene

24. Last seen alive_____ AM/PM; Was infant behaving normally? □ Yes, □ No; If no, describe:_____
25. Who discovered the infant? Name_____; Relationship _____; Time _____AM/PM
26. Position infant was in when found? □ Abdomen, □ Back, □ Side; Position when put to bed? □ Abdomen, □ Back, □ Side;
What was the infant wearing? _____; How was the infant covered?
_____
27. Were the nose and mouth obstructed? □ Yes, □ No; If yes, with or by what?
_____
28. Describe infant's sleeping environment: □ Crib, □ Bed, □ Sofa, □ Other _____; Type of mattress: □ Soft, □ Hard,
□ Waterbed, □ Exposed plastic covering. Were any of the following found in infant's bed?
□ Pillow, □ Blankets, □ Cushions, □ Toys, □ Pets,
□ Other_____;
Temperature of room: _____
29. Was the infant sleeping alone? □ Yes, □ No; If no, with whom? □ Child, □ Adult, □ More than one person; Estimated weight of sleeper(s):_____ ; Drug or alcohol used? □ Yes, □ No; If yes, what?_____
30. Was the infant: □ Warm, □ Cool
31. Were attempts made to revive the infant? □ Yes, □ No; If yes, by whom?
_____; Time of attempt _____AM/PM;
Method of attempt: □ CPR, □ Shaken, Other
_____
32. Does anyone in the immediate household or daycare facility smoke? □ Yes, □ No; If yes, identify relationship: _____

Comments: (Use this space to elaborate on questions above or to note anything unusual)

_____
_____
_____
_____
_____

*Use "Comments" section if more space is needed. Collect all medication/home remedy containers for submission to Medical Examiner.