U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
Division of Reproductive Health
Maternal and Infant Health Branch
Atlanta, Georgia 30333

Sudden Unexplained Infant Death Investigation

# SUIDI

Reporting Form

## ADDITIONAL INVESTIGATIVE SCENE FORMS

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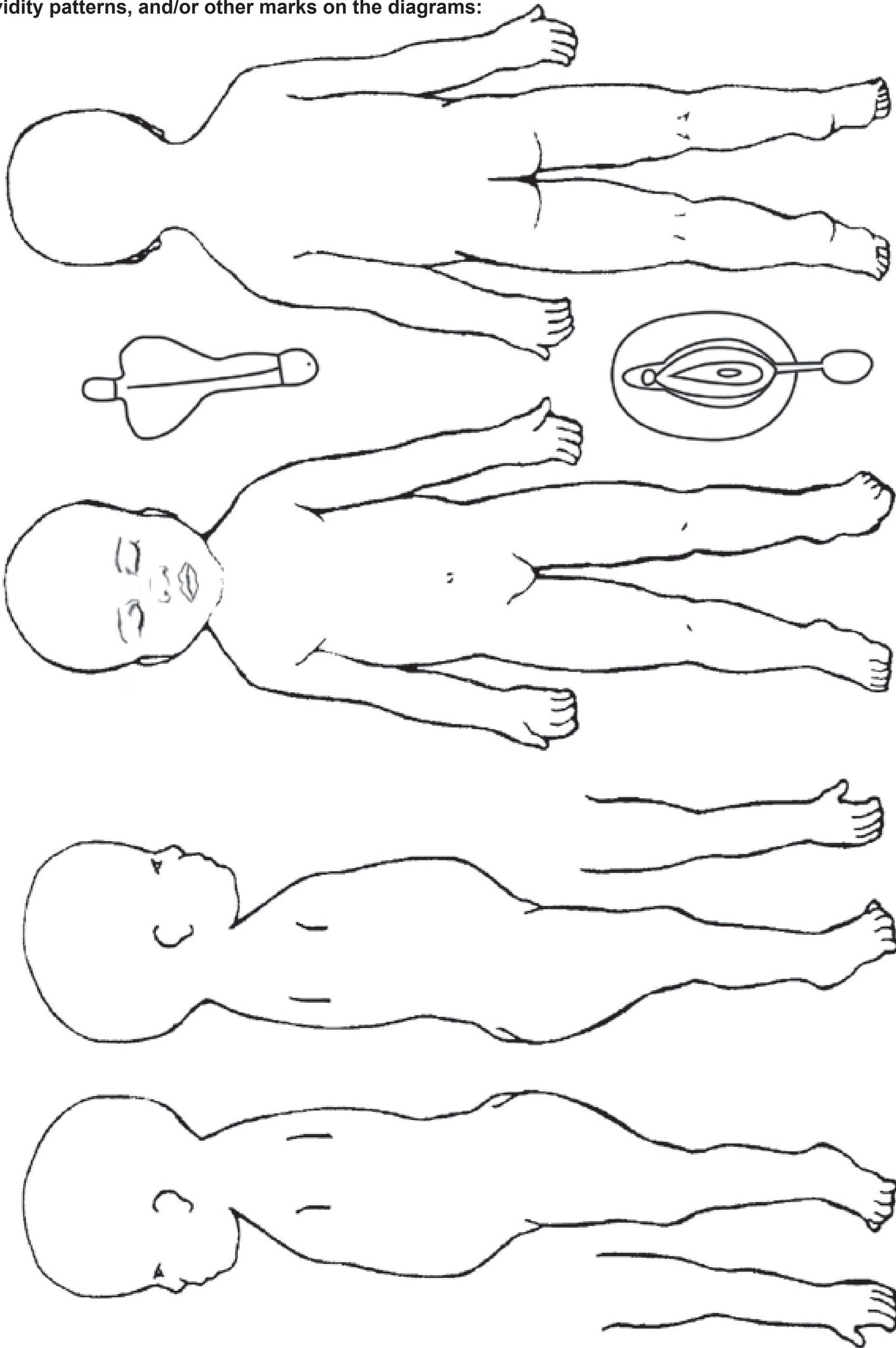
**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **Draw lividity patterns, and/or other marks on the diagrams:**



A - BODY DIAGRAM

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

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A - BODY DIAGRAM

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **Information about the EMS responder:**

| Last name | First name | Agency |
|---|---|---|
| | | |

| | Month | Day | Year | Military Time |
|---|---|---|---|---|
| Date/Time Dispatched: | | | | : |

**2** **Who called 911?**

| Last name | First name | Relationship *(example aunt)* |
|---|---|---|
| | | |

**3** **What date and time did you arrive?**

| Month | Day | Year | Military Time |
|---|---|---|---|
| | | | : |

**4** **Was anyone doing CPR when EMS arrived?**

| No | Yes | Who? |
|---|---|---|
| | | |

**5** **Where was the infant when you arrived at the scene?** *(ex. crib, arms of caregiver)*

**6** **Describe infant's appearance when found.**

| Appearance | No | Yes | Describe and specify location: |
|---|---|---|---|
| a) Discoloration around face/nose/mouth | | | |
| b) Secretions (foam, froth) | | | |
| c) Skin discoloration (livor mortis) | | | |
| d) Pressure marks (pale, blanching) | | | |
| e) Rash or petechiae (small, red blood spots on skin, membranes or eyes) | | | |
| f) Marks on body (scratch on nose) | | | |
| g) Other | | | |
| h) Unknown | | | |

**7** **How did the infant feel when found?**

| Sweaty | Warm to touch | Cool to touch | Rigid, stiff | Limp, flexible | Unknown | Other - specify |
|---|---|---|---|---|---|---|
| | | | | | | |

**8** **Did you administer resuscitative efforts?** If Yes - *check all that were done below,* If No - Skip to No. 13 on next page.

| CPR | IV/IO Access | Gastric Tube | Infant immobilized | Medications | Intubation | Electric shock |
|---|---|---|---|---|---|---|
| | | | | | | |

Other - Specify:

**9** **List all emergency medications given to the infant:**

| Name of Medication | Dose | Route | Military Time |
|---|---|---|---|
| 1. | | | : |
| 2. | | | : |
| 3. | | | : |
| 4. | | | : |
| 5. | | | : |

Continued on the next page ►

B - EMS INTERVIEW

B - EMS INTERVIEW

**10** **Describe the nature and duration of resuscitation efforts and treatments.**

**11** **Describe any injuries sustained by infant during resuscitative efforts (if any):**

**12** **At what date and approximate time were the resuscitative efforts terminated?**

| Not terminated by EMS | Month | Day | Year | Military Time |
|---|---|---|---|---|
| | | | | : |

**13** **What was the name of the authorizing medical control physician who pronounced death?**

| Last name | First name | Agency |
|---|---|---|
| | | |

**14** **What was the final disposition of the infant?**

| Left at the scene | Released to funeral home | Morgue | ME/C facility |
|---|---|---|---|
| | | | |

| Transported to the hospital - Specify | Other - Specify | Name of person who received the infant |
|---|---|---|
| | | |

**15** **Describe the reaction of the caregiver(s) to the infant's death:**

**16** **Additional comments from the EMS personnel:** *(Describe concerns with scene or what happened)*

## Investigator's Notes

| | EMS Run Report/Sheet | 911 Tape |
|---|---|---|
| **Indicate the task(s) performed** | | |

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

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**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **On what day and at what approximate time did the infant arrive at the hospital?**

| Month | Day | Year | Military Time |
|---|---|---|---|
| | | | : |

**2** **Hospital Information:**

Hospital Name: ______ Address: ______

**3** **Name of physician responsible for treatment at hospital.**

Name: ______ Phone: ______

**4** **Name physician who signed the death certificate.**

Name: ______ Phone: ______

**5** **What was the level of consciousness upon arrival at the hospital?**

☐ Breathing ☐ Not breathing ☐ Responsive ☐ Unresponsive ☐ Dead

**What did the infant look like upon arrival at the hospital? (***Check all that apply)*

| Appearance | No | Yes | Describe and specify location: |
|---|---|---|---|
| a) Discolorations | | | |
| b) Secretions | | | |
| c) Livor mortis | | | |
| d) Pale areas around nose or mouth | | | |
| e) Retinal hemorrhages | | | |
| f) Cutaneous petechiae | | | |
| g) Bruising or other injury | | | |
| h) Suspicion of inflicted trauma | | | |
| i) Malnourished | | | |
| j) Other | | | |

**6** **How did the infant feel upon arrival at the hospital?**

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Rigid, stiff ☐ Limp, flexible ☐ Unknown

Other - Specify: ______

**7** **List all treatments and procedures (T&P) administered to the infant at the hospital:**

| Treatment or Procedure | Approx. Time | Outcome |
|---|---|---|
| 1. | : | |
| 2. | : | |
| 3. | : | |
| 4. | : | |

**8** **Hospital staff's comments regarding family's reaction to infant's death.**

______

## Investigator's Notes

| Indicate the task(s) performed | Obtain medical records or code sheet | Secure evidence and release infant's property |
|---|---|---|
| | | |

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

C - HOSPITAL INTERVIEW

C - HOSPITAL INTERVIEW

D - IMMUNIZATION RECORD

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **Indicate information source** *(Check appropriate box)*

- ☐ Biological Mother/Father
- ☐ Grandmother/Father
- ☐ Adoptive or Foster Parents
- ☐ Physician
- ☐ Health Records
- ☐ Other (specify):

**2** **Has the infant ever received immunizations or shots?**

| Yes | No - (stop) |
|---|---|
| | |

**Please list all of the immunizations the infant has ever been given or attach record.**

| Immunization: | Month | Day | Year | Comments/Reactions: |
|---|---|---|---|---|
| Hepatitis B #1 | | | | |
| Hepatitis B #2 | | | | |
| Hepatitis B #3 | | | | |
| Diphtheria, Tetanus, Pertussis #1 (DPT) | | | | |
| Diphtheria, Tetanus, Pertussis #2 (DPT) | | | | |
| Diphtheria, Tetanus, Pertussis #3 (DPT) | | | | |
| Haemophilus Influenzae Type b #1 (Hib) | | | | |
| Haemophilus Influenzae Type b #2 (Hib) | | | | |
| Haemophilus Influenzae Type b #3 (Hib) | | | | |
| Inactivated Poliovirus #1 (Polio) | | | | |
| Inactivated Poliovirus #2 (Polio) | | | | |
| Inactivated Poliovirus #3 (Polio) | | | | |
| Measles, Mumps, Rubella (MMR) | | | | |
| Varicella (Chicken Pox) | | | | |
| Pneumococcal | | | | |
| Influenza (Flu) | | | | |
| Hepatitis A #1 | | | | |
| Hepatitis A #2 | | | | |
| Other/Specify: | | | | |

**3** **Are the immunizations up to date?**

| Yes | No | Unknown |
|---|---|---|
| | | |

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

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**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **Identify all persons who were in contact with the infant in the 24 hours prior to the infant's death.**
*(being in the same room, living in/staying in/visiting the infant's primary residence - if more than 3 persons, use additional pages)*

| | **Person 1** | | | **Person 2** | | | **Person 3** | | |
|---|---|---|---|---|---|---|---|---|---|
| a) Last name | | | | | | | | | |
| b) First name | | | | | | | | | |
| c) Maiden name *(if applicable)* | | | | | | | | | |
| d) Relationship to infant | | | | | | | | | |
| e) Street | | | | | | | | | |
| f) City | | | | | | | | | |
| h) DOB | Month | Day | Year | Month | Day | Year | Month | Day | Year |
| | | | | | | | | | |
| i) Where did contact with the infant occur (*ex. house, daycare, playground)* | | | | | | | | | |
| j) Date of last contact with the infant | Month | Day | Year | Month | Day | Year | Month | Day | Year |
| | | | | | | | | | |
| k) Approximate time of last contact with the infant *(Military Time)* | : | | | : | | | : | | |
| l) During the week prior to the infant's death, was this person sick? *(If "Yes", explain the circumstances below)* | Yes | No | Unknown | Yes | No | Unknown | Yes | No | Unknown |
| | | | | | | | | | |
| | Explain: | | | Explain: | | | Explain: | | |
| m) For persons biologically related to the infant *(d above)* are there any known conditions/diseases that run in the family? *(down syndrone)* | Yes | No | NA | Yes | No | NA | Yes | No | NA |
| | | | | | | | | | |
| | Explain: | | | Explain: | | | Explain: | | |
| n) Has this person experienced the death of any of their own children or of any other children while in their care? | Yes | No | Unknown | Yes | No | Unknown | Yes | No | Unknown |
| | | | | | | | | | |
| | Explain: | | | Explain: | | | Explain: | | |
| I) Child's name | | | | | | | | | |
| II) Relationship to caregiver | | | | | | | | | |
| III) Date of death | Month | Day | Year | Month | Day | Year | Month | Day | Year |
| | | | | | | | | | |
| IV) Child's age at death (years or months if <2 years) | | | | | | | | | |
| V) Cause of death | | | | | | | | | |
| VI) Place of death (City/State) | | | | | | | | | |

| | No | Yes | If yes - please describe |
|---|---|---|---|
| **2** **Did the infant visit a location with large numbers of people within the last 24 hours?** | | | |
| **3** **Are there any factors, circumstances, or environmental concerns?** *(ex. mother smoked while breast feeding, exposed to a large number of people at church or a public event, air travel)* | | | |

E - INFANT EXPOSURE HISTORY

Continued on the next page ►

**4** **Daycare**

| | Yes | No |
|---|---|---|
| Did the infant visit a daycare in the 24 hours prior to the death? | | |

How many adults were supervising the children? Number of people (18 years or older) ______

| | No | Yes | If yes - specify |
|---|---|---|---|
| Were any of these adults sick? | | | |

How many children were under the care of the provider at that day? Number of people (18 years or older) ______

Identify any children in daycare who were sick and were in contact or close proximity to the infant in the 24 hours prior to the death?

| | Child 1 | | | Child 2 | | | Child 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| a) First name of child | | | | | | | | | |
| b) Last name of child | | | | | | | | | |
| c) Date of birth | Month | Day | Year | Month | Day | Year | Month | Day | Year |
| | | | | | | | | | |
| d) Where did contact with the infant occur *(ex. house, daycare, play-ground)* | | | | | | | | | |
| e) Date of last contact with the infant | Month | Day | Year | Month | Day | Year | Month | Day | Year |
| | | | | | | | | | |
| f) Approximate time of last contact with the infant | | | | | | | | | |
| g) During the week prior to the infant's death, was this person sick? *(If "Yes", explain the circumstances)* | Yes | No | Unknown | Yes | No | Unknown | Yes | No | Unknown |
| | | | | | | | | | |
| | Explain: | | | Explain: | | | Explain: | | |

***If more than 3 children, use additional pages***

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

E - INFANT EXPOSURE HISTORY

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **For each informant interviewed, please obtain the following information:**

**Informant 1**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

**Informant 2**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

**Informant 3**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

**Informant 4**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

**Informant 5**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

**Informant 6**

| | |
|---|---|
| a) First/Last Name: | |
| a) Maiden (if applicable): | |
| c) Relationship to Infant: | |
| d) Address (H): | |
| e) City: | |
| f) Address (W): | |
| g) City: | |
| h) State: | |
| h) Zip: | |
| i) Phone 1: | |
| j) Phone 2: | |

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

F - INFORMANT CONTACT

G - LAW ENFORCEMENT INTERVIEW

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**Information about the Law Enforcement officer:**

| Last name | Middle name | Last name |
|---|---|---|
| | | |

| Phone number | Agency |
|---|---|
| | |

Date and time dispatched:

| Month | Day | Year | Military Time |
|---|---|---|---|
| | | | : |

Who called? ____________ Relationship *(ex. aunt):* ____________

**1** **What date and time did you arrive?**

| Month | Day | Year | Military Time |
|---|---|---|---|
| | | | : |

**2** **What did the infant look like when you arrived at the scene?**

| Appearance | No | Yes | Describe and specify location: |
|---|---|---|---|
| a) Discoloration around face/nose/mouth | | | |
| b) Secretions *(foam, froth)* | | | |
| c) Skin discoloration *(livor mortis)* | | | |
| d) Pressure marks *(pale, blanching)* | | | |
| e) Rash or petechiae *(small, red blood spots on skin, membranes or eyes)* | | | |
| f) Marks on body *(scratch on nose)* | | | |
| g) Other | | | |
| h) Unknown | | | |

**3** **How did the infant feel when found?**

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Rigid, stiff ☐ Limp, flexible ☐ Unknown

Other - Specify: ____________

**4** **How would you describe the surface on which the infant was placed?**

Condition of surface (check all that apply): ☐ Soft ☐ Firm ☐ Lumpy ☐ Concave ☐ Stained ☐ Wet

**5** **Describe condition:** (check all that apply):

☐ Broken ☐ Worn ☐ Repaired ☐ Clean ☐ Dirty

**6** **Describe what the scene looked like upon arrival:**

____________

**7** **Describe what law enforcement did at the scene:**

____________

**8** **Describe the person's reactions to the infant's death:**

| Individual | No | Yes | Specify: |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Placer | | | |
| Finder | | | |
| Last Known Alive | | | |
| Other | | | |

Continued on the next page ►

G - LAW ENFORCEMENT INTERVIEW

**8** **Are there any known prior contacts with law enforcement?**

| Individual | No | Yes | Reason for contact | Outcome |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Placer | | | | |
| Finder | | | | |
| Last Known Alive | | | | |
| Other | | | | |

**9** **What was the final disposition of the infant?**

☐ Left at the scene ☐ Released to funeral home ☐ Morgue ☐ ME/C facility

☐ Transported to the hospital - Specify: ______

☐ Other - Specify: ______

*(Indicate facility name and name of person who received the infant)*

**10** **Have there been any contacts/complaints to social services regarding this family and other siblings in the home?**

| Yes | No - (stop) |
|---|---|
| | |

**11** **Total number of contacts with social services:**

______

**12** **List up to two most recent contacts with social services.**

| | Month | Day | Year |
|---|---|---|---|
| Date contacted: | | | |

Caseworker name: ______

Agency name: ______

Reason for contact: ______

Outcome: ______

Comments: ______

| | Month | Day | Year |
|---|---|---|---|
| Date contacted: | | | |

Caseworker name: ______

Agency name: ______

Reason for contact: ______

Outcome: ______

Comments: ______

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**8** **Describe all items recovered from the site of the incident or death scene:**

| Item | Evidence No. | Origin | Description | Disposition | Name of person collecting |
|---|---|---|---|---|---|
| 1) Baby bottles | | | | | |
| 2) Pacifier | | | | | |
| 3) Formula | | | | | |
| 4) Bedding | | | | | |
| 5) Infant's last diaper | | | | | |
| 6) Clothing | | | | | |
| 7) Apnea monitor | | | | | |
| 8) Infant sleep surface | | | | | |
| 9) Medicines *(include home remedies)* | | | | | |
| 10) | | | | | |
| 11) | | | | | |
| 12) | | | | | |
| 13) | | | | | |
| 14) | | | | | |
| 15) | | | | | |
| 16) | | | | | |
| 17) | | | | | |
| 18) | | | | | |
| 19) | | | | | |
| 20) | | | | | |
| 21) | | | | | |
| 22) | | | | | |
| 23) | | | | | |
| 24) | | | | | |
| 25) | | | | | |
| 26) | | | | | |
| 27) | | | | | |
| 28) | | | | | |
| 29) | | | | | |
| 30) | | | | | |

H - MATERIALS COLLECTION LOG

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**1** **Information about the person who was the first non-professional responder to the infant:**

| Last name | Middle name | Last name |
|---|---|---|
| | | |

| Phone number | Relationship to infant |
|---|---|
| | |

☐ Male ☐ Female Age: ____ Date of Birth: ____

**2** **What led you to respond?**

**3** **When the infant was found, was s/he:**

☐ breathing ☐ not breathing ☐ unresponsive

If not breathing, did you witness the infant stop breathing? ☐ yes ☐ no

**4** **Describe infant's appearance when found.**

| Appearance | No | Yes | Describe and specify location: |
|---|---|---|---|
| a) Discoloration around face/nose/mouth | | | |
| b) Secretions *(foam, froth)* | | | |
| c) Skin discoloration *(livor mortis)* | | | |
| d) Pressure marks *(pale, blanching)* | | | |
| e) Rash or petechiae *(small, red blood spots on skin, membranes or eyes)* | | | |
| f) Marks on body *(scratch on nose)* | | | |
| g) Other | | | |
| h) Unknown | | | |

**5** **How did the infant feel when found?**

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Rigid, stiff ☐ Limp, flexible ☐ Unknown

Other - Specify:

**6** **What date and time were the first resuscitative efforts given?**

| Month | Day | Year | Military Time |
|---|---|---|---|
| | | | : |

**7** **Where were resuscitative efforts conducted?**

**8** **Describe what you did as part of the resuscitative efforts (ex. pushed on chest and breathed into mounth and nose):**

**9** **Have you ever received any First Aid and/or CPR training?**

☐ No ☐ Yes When:

Describe:

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

I - NONPROFESSIONAL RESPONDER INTERVIEW

J - PARENTAL INFORMATION

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**Indicate information source**

☐ Biological Mother/Father ☐ Grandmother/Father ☐ Adoptive or Foster Parents ☐ Physician ☐ Health Records

Other - Specify: ____________________

**1 Information about the infant's mother:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______ Maiden name: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the mother been a resident of this state? Years: ______ Months: ______

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

**2 Information about the infant's biological mother:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______ Maiden name: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the mother been a resident of this state? Years: ______ Months: ______

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

**3 Information about the infant's father:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the father been a resident of this state? Years: ______ Months: ______

Has the father ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

**4 Information about the infant's biological father:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the father been a resident of this state? Years: ______ Months: ______

Has the father ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

Continued on the next page ►

J - PARENTAL INFORMATION

**5** **Information about the infant's other primary caregivers:** (ex. babysitter while parents are at work)

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______ Maiden name: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the caregiver been a resident of this state? Years: ______ Months: ______

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

**6** **Information about the infant's other primary caregivers:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______ Maiden name: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the caregiver been a resident of this state? Years: ______ Months: ______

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

**7** **Information about the infant's other primary caregivers:**

First name: ______ Middle name: ______ Last name: ______

DOB: ______ SS#: ______ Maiden name: ______

*Current address:*

Street: ______ City: ______ State: ______ Zip: ______

How long has the caregiver been a resident of this state? Years: ______ Months: ______

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states: ______

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

**Infant's Information**

| Last Name | First Name | Middle | Case Number |
|---|---|---|---|
| | | | |

**Complete this form only if the scene of the incident or death scene is *NOT* the primary residence.**

**1 Address of primary residence:**

Street: ____ City: ____ State: ____ Zip: ____

**2 How many people live at the infant's primary residence?**

Number of adults *(18 years or older)*: ____ Number of children *(under 18 years old)*: ____

**3 What type of building is the primary residence?**

- [ ] Apartment
- [ ] Single family house
- [ ] Multifamily home
- [ ] Mobile home
- [ ] Institution (ex. shelter)
- [ ] Other Specify: ____

**4 Which of the following heating or cooling sources were being used?** *(Check all that apply)*

- [ ] Central air
- [ ] A/C window unit
- [ ] Ceiling fan
- [ ] Electric baseboard heat
- [ ] Gas furnace or boiler
- [ ] Electric furnace or boiler
- [ ] Electric space heater
- [ ] Electric (radiant) ceiling heat
- [ ] Wood burning fireplace
- [ ] Coal burning furnace
- [ ] Kerosene space heater
- [ ] Window fan
- [ ] Open window(s)
- [ ] Wood burning stove
- [ ] Floor/table fan
- [ ] Unknown
- [ ] Other - specify: ____

**5 The infant's primary residence has:** *(Check all that apply)*

- [ ] Insects
- [ ] Pets
- [ ] Peeling paint
- [ ] Rodents or vermin
- [ ] Mold growth
- [ ] Dampness
- [ ] Visible standing water
- [ ] Odors or fumes - Describe: ____
- [ ] Smoky smell *(like cigarettes)*
- [ ] Presence of alcohol containers
- [ ] Presence of drug paraphenalia

Other - specify:

**6 What was the source of drinking water at the infant's primary residence?** *(Check all that apply)*

- [ ] Public/Municipal water source
- [ ] Well
- [ ] Bottled water
- [ ] Unknown
- [ ] Other - specify: ____

**7 What is the general appearance of the infant's primary residence?** *(ex. cleanliness, hazards, overcrowding, etc.)*

| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

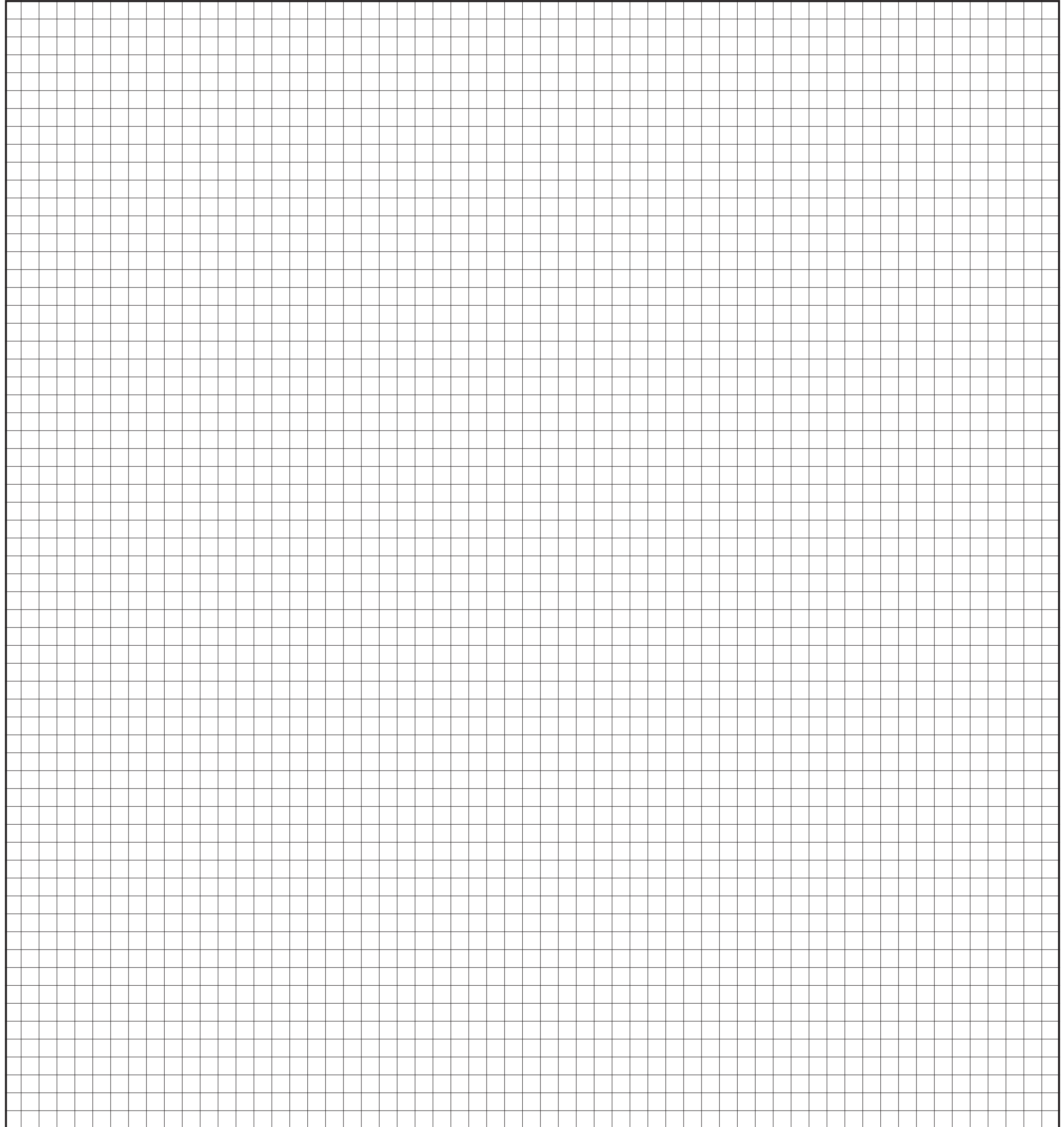
K - PRIMARY RESIDENCE INVESTIGATION

**Infant's Information**

| last name | first name | middle | case number |
|---|---|---|---|
| | | | |

**1** **Draw the following on the scene diagram.** *(For people and objects, give the name, show location, show position)*

a) Room dimensions and North Direction
b) Crib, bed or sleep surface
c) Infant's position when found
d) Those sharing the same sleeping surface
e) Furniture and other objects in room
f) Heating and cooling sources
g) Items in contact with the infant



| Section Completed by (name) | Month | Day | Year | Military Time | In person | Telephone | Other |
|---|---|---|---|---|---|---|---|
| | | | | : | | | |

L - SCENE DIAGRAM

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