

CASE NUMBER

State / County or Team Number / Year of Review / Sequence of Review	Case Type: <input type="radio"/> Death	Death Certificate Number:
	<input type="radio"/> Near death/serious injury	Birth Certificate Number:
	<input type="radio"/> Not born alive	ME/Coroner Number:
		Date CDRT Notified of Death:

A. CHILD INFORMATION

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	4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K	5. Race, check all that apply: <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander, specify: <input type="checkbox"/> Asian, specify: <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> Alaskan Native, Tribe:	6. Hispanic or Latino origin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																								
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____		9. 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		10. New residence in past 30 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																									
11. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	12. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	13. Number of other children living with child: _____ <input type="checkbox"/> U/K	14. Child's weight: <input type="checkbox"/> U/K <input type="radio"/> Pounds/ounces _____ <input type="radio"/> Grams/kilograms _____	15. Child's height: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ <input type="radio"/> Cm _____																									
16. Highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12		17. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K	18. Did child have problems in school? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> U/K <input type="checkbox"/> Other, specify:		19. Child's health insurance, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																								
20. 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		21. Child's mental health (MH): Child had received prior MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child was receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child on medications for MH illness? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Issues prevented child from receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:		22. Child had history of substance abuse? <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"/> Other, specify: <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> U/K <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs																									
23. Child had history of child maltreatment? If yes, check all that apply: <table border="1"><tr><td><u>As Victim</u></td><td><u>As Perpetrator</u></td><td><u>As Victim</u></td><td><u>As Perpetrator</u></td></tr><tr><td><input type="radio"/> N/A</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/> Physical</td></tr><tr><td><input type="radio"/> Yes</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/> Neglect</td></tr><tr><td><input type="radio"/> No</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/> Sexual</td></tr><tr><td><input type="radio"/> U/K</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/> Emotional/psychological</td></tr><tr><td></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/> U/K</td></tr></table> If yes, how was history identified: <input type="radio"/> Through CPS <input type="radio"/> Other sources		<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>	<input type="radio"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neglect	<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual	<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional/psychological		<input type="checkbox"/>	<input type="checkbox"/>	<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		27. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K																										
28. Child had delinquent or criminal history? <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"/> Assaults <input type="checkbox"/> Other, specify: <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> U/K		29. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		32. If child over age 12, what was child's gender identity? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																									
		30. Child acutely ill during the two weeks before death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																											
		31. Was any parent a first generation immigrant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, country of origin: _____		33. If child over age 12, what was child's sexual orientation? <input type="radio"/> Heterosexual <input type="radio"/> Lesbian <input type="radio"/> Questioning <input type="radio"/> Gay <input type="radio"/> Bisexual <input type="radio"/> U/K																									

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____/____	36. Multiple birth? <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K	37. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K	38. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K
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39. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K	40. 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: # _____ <input type="checkbox"/> U/K If yes, month of first prenatal visit: Specify 1-9 ____ <input type="checkbox"/> U/K
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41. During pregnancy, did mother (check all that apply): Yes No U/K <input type="radio"/> <input type="radio"/> <input type="radio"/> Have medical complications/infections? <input type="radio"/> <input type="radio"/> <input type="radio"/> Experience intimate partner violence? <input type="radio"/> <input type="radio"/> <input type="radio"/> Use illicit drugs? <input type="checkbox"/> Infant born drug exposed? <input type="radio"/> <input type="radio"/> <input type="radio"/> Misuse OTC or prescription drugs? <input type="radio"/> <input type="radio"/> <input type="radio"/> Have heavy alcohol use? <input type="checkbox"/> Infant born with fetal alcohol effects or syndrome?	If yes, medical complications/infections, check all that apply: <input type="checkbox"/> Acute/chronic lung disease <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Previous infant 4000+ grams <input type="checkbox"/> Anemia <input type="checkbox"/> High MSAFP <input type="checkbox"/> Previous infant preterm/small for gestation <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Hydramnios/oligohydramnios <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> PROM <input type="checkbox"/> Chronic hypertension <input type="checkbox"/> Low MSAFP <input type="checkbox"/> Renal disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other infectious disease <input type="checkbox"/> Rh sensitization <input type="checkbox"/> Eclampsia <input type="checkbox"/> Pregnancy-related hypertension <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Genital herpes <input type="checkbox"/> Preterm labor <input type="checkbox"/> Other, specify: _____
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42. Were there access or compliance issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Cultural differences <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Lack of child care <input type="checkbox"/> Intimate partner would not allow care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Language barriers <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Referrals not made <input type="checkbox"/> Services not available <input type="checkbox"/> U/K <input type="checkbox"/> No phone <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Distrust of health care system	If yes, check all that apply:
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43. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, _____ Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> U/K quantity	44. Did mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Trimester 1</td> <td style="text-align: center;">Trimester 2</td> <td style="text-align: center;">Trimester 3</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> If yes, _____ Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> U/K quantity	Trimester 1	Trimester 2	Trimester 3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimester 1	Trimester 2	Trimester 3									
_____	_____	_____									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									

45. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	46. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: _____	47. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was abnormality a fatty acid oxidation error, such as MCAD? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: _____ If other abnormalities, describe: _____
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48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply): <input type="checkbox"/> Infection <input type="checkbox"/> Cyanosis <input type="checkbox"/> Allergies <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Apnea <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Other, specify: _____	49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Apnea <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Choking <input type="checkbox"/> Cyanosis <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Diarrhea <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Stool changes <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Difficulty breathing
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50. 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: _____	51. 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: _____	52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name and last dose given: _____	53. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Formula, type: _____ <input type="checkbox"/> Baby food, type: _____ <input type="checkbox"/> Cereal, type: _____ <input type="checkbox"/> U/K
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B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two. <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> <table style="width:100%; border-collapse: collapse;"> <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"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table> </td> <td style="width:50%; padding: 5px;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td>_____ # Years</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table> </td> </tr> </table>	<table style="width:100%; border-collapse: collapse;"> <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"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section C	<input type="radio"/> Grandparent	<input type="radio"/> Biological parent	<input type="radio"/> Sibling	<input type="radio"/> Adoptive parent	<input type="radio"/> Other relative	<input type="radio"/> Stepparent	<input type="radio"/> Friend	<input type="radio"/> Foster parent	<input type="radio"/> Institutional staff	<input type="radio"/> Mother's partner	<input type="radio"/> Other, specify: _____	<input type="radio"/> Father's partner	<input type="radio"/> U/K	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td>_____ # Years</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	_____ # Years	_____ # Years	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	2. Caregiver(s) age in years: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td>_____ # Years</td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	_____ # Years	_____ # Years	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	3. Caregiver(s) sex: <table style="width:100%; border-collapse: collapse;"> <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"/> Male</td> <td><input type="radio"/> Male</td> </tr> <tr> <td><input type="radio"/> Female</td> <td><input type="radio"/> Female</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Male	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Female	<input type="radio"/> U/K	<input type="radio"/> U/K	4. Caregiver(s) employment status: <table style="width:100%; border-collapse: collapse;"> <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"/> Employed</td> <td><input type="radio"/> Employed</td> </tr> <tr> <td><input type="radio"/> Unemployed</td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/> On disability</td> </tr> <tr> <td><input type="radio"/> Stay-at-home</td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/> Retired</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> Retired	<input type="radio"/> U/K	<input type="radio"/> U/K	5. Caregiver(s) income: <table style="width:100%; border-collapse: collapse;"> <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"/> High</td> <td><input type="radio"/> High</td> </tr> <tr> <td><input type="radio"/> Medium</td> <td><input type="radio"/> Medium</td> </tr> <tr> <td><input type="radio"/> Low</td> <td><input type="radio"/> Low</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> High	<input type="radio"/> High	<input type="radio"/> Medium	<input type="radio"/> Medium	<input type="radio"/> Low	<input type="radio"/> Low	<input type="radio"/> U/K	<input type="radio"/> U/K
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<input type="radio"/> Employed	<input type="radio"/> Employed																																																																	
<input type="radio"/> Unemployed	<input type="radio"/> Unemployed																																																																	
<input type="radio"/> On disability	<input type="radio"/> On disability																																																																	
<input type="radio"/> Stay-at-home	<input type="radio"/> Stay-at-home																																																																	
<input type="radio"/> Retired	<input type="radio"/> Retired																																																																	
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<input type="radio"/> U/K	<input type="radio"/> U/K																																																																	

6. Caregiver(s) education: <table style="width:100%; border-collapse: collapse;"> <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"/> < High school</td> <td><input type="radio"/> < High school</td> </tr> <tr> <td><input type="radio"/> High school</td> <td><input type="radio"/> High school</td> </tr> <tr> <td><input type="radio"/> College</td> <td><input type="radio"/> College</td> </tr> <tr> <td><input type="radio"/> Post graduate</td> <td><input type="radio"/> Post graduate</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> < High school	<input type="radio"/> < High school	<input type="radio"/> High school	<input type="radio"/> High school	<input type="radio"/> College	<input type="radio"/> College	<input type="radio"/> Post graduate	<input type="radio"/> Post graduate	<input type="radio"/> U/K	<input type="radio"/> U/K	7. Do caregiver(s) speak English? <table style="width:100%; border-collapse: collapse;"> <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"/> Yes</td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> If no, language spoken: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	8. Caregiver(s) on active military duty? <table style="width:100%; border-collapse: collapse;"> <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"/> Yes</td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> If yes, specify branch: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	9. Caregiver(s) receive social services in the past twelve months? <table style="width:100%; border-collapse: collapse;"> <tr> <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"/> Yes</td> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> WIC</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> TANF</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Food stamps</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table> If yes, check all that apply	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> WIC	<input type="radio"/> No	<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/> TANF	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/> Medicaid			<input type="checkbox"/>	<input type="checkbox"/> Food stamps			<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____			<input type="checkbox"/>	<input type="checkbox"/> U/K
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		<input type="checkbox"/>	<input type="checkbox"/> U/K																																																								

<p>10. Caregiver(s) have substance abuse history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>11. Caregiver(s) ever victim of child maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted</p>	<p>12. Caregiver(s) ever perpetrator of maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed</p>	<p>13. Caregiver(s) have disability or chronic illness?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental illness, was caregiver receiving MH services?</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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<p>14. Caregiver(s) have prior child deaths?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>15. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>16. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
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C. SUPERVISOR INFORMATION

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> Yes, answer 2-15</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sect. D</p> <p><input type="radio"/> No, but needed, answer 3-15</p> <p><input type="radio"/> Unable to determine, try to answer 3-15</p>	<p>2. How long before incident did supervisor last see child? Select one:</p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____ <input type="radio"/> Days _____</p> <p><input type="radio"/> Hours _____ <input type="radio"/> U/K</p>	<p>3. Is person a primary caregiver as listed in previous section?</p> <p><input type="radio"/> Yes, caregiver one, go to 15</p> <p><input type="radio"/> Yes, caregiver two, go to 15</p> <p><input type="radio"/> No</p>
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4. Primary person responsible for supervision? Select only one:

Biological parent Foster parent Grandparent Friend Institutional staff, go to 15 Other, specify:
 Adoptive parent Mother's partner Sibling Acquaintance Babysitter
 Stepparent Father's partner Other relative Hospital staff, go to 15 Licensed child care worker U/K

<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</p>	<p>7. Does supervisor speak English?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
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<p>9. Supervisor has substance abuse history?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care/adopted</p> <p><input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> Children ever removed</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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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	14. Supervisor has delinquent or criminal history? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Drugs <input type="checkbox"/> U/K <input type="checkbox"/> Robbery <input type="checkbox"/> Other, specify: _____	15. At time of incident was supervisor impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, check all that apply: <input type="checkbox"/> Drug impaired, specify: _____ <input type="checkbox"/> Absent <input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Impaired by illness, specify: _____ <input type="checkbox"/> Asleep <input type="checkbox"/> Impaired by disability, specify: _____ <input type="checkbox"/> Distracted <input type="checkbox"/> Other, specify: _____
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D. INCIDENT INFORMATION

1. Date of incident event: <input type="checkbox"/> Same as date of death <input type="checkbox"/> If different than date of death: ____/____/____ <input type="checkbox"/> U/K (mm/dd/yyyy)	2. Approximate time of day that incident occurred? Hour, specify 1-12 ____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> U/K	3. Interval between incident and death: <input type="checkbox"/> U/K <input type="checkbox"/> Minutes ____ <input type="checkbox"/> Weeks ____ <input type="checkbox"/> Hours ____ <input type="checkbox"/> Months ____ <input type="checkbox"/> Days ____ <input type="checkbox"/> Years ____
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4. Place of incident, check all that apply: <input type="checkbox"/> Child's home <input type="checkbox"/> Licensed group home <input type="checkbox"/> School <input type="checkbox"/> Sidewalk <input type="checkbox"/> Sports area <input type="checkbox"/> Relative's home <input type="checkbox"/> Licensed child care center <input type="checkbox"/> Place of work <input type="checkbox"/> Roadway <input type="checkbox"/> Other recreation area <input type="checkbox"/> Friend's home <input type="checkbox"/> Licensed child care home <input type="checkbox"/> Indian reservation <input type="checkbox"/> Driveway <input type="checkbox"/> Hospital <input type="checkbox"/> Licensed foster care home <input type="checkbox"/> Unlicensed child care home <input type="checkbox"/> Military installation <input type="checkbox"/> Other parking area <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Relative foster care home <input type="checkbox"/> Farm <input type="checkbox"/> Jail/detention facility <input type="checkbox"/> State or county park <input type="checkbox"/> U/K	5. Type of area: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural <input type="checkbox"/> Frontier <input type="checkbox"/> U/K
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6. Incident state: _____	7. Incident county: _____	8. Death state: _____	9. Death county: _____	10. Was the incident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UK If yes, by whom? <input type="checkbox"/> Parent/relative <input type="checkbox"/> Health care professional, if death occurred in a hospital setting <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Stranger <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Other, specify: _____
11. Was 911 or local emergency called? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K				

12. Was resuscitation attempted? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, by whom? <input type="checkbox"/> EMS <input type="checkbox"/> Stranger <input type="checkbox"/> Parent/relative <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Other caretaker/babysitter <input type="checkbox"/> Teacher/coach/athletic trainer <input type="checkbox"/> Other acquaintance <input type="checkbox"/> Health care professional, if death occurred in a hospital setting	If yes, type of resuscitation: <input type="checkbox"/> CPR <input type="checkbox"/> Automated External Defibrillator (AED) If no AED, was AED available/accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If AED, was shock administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, how many shocks were administered? _____ <input type="checkbox"/> Rescue medications, specify type: _____ <input type="checkbox"/> Other, specify: _____	If yes, was a rhythm recorded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, what was the rhythm? _____
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13. At time of incident leading to death, had child used drugs or alcohol? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K	14. 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: _____	15. Total number of deaths at incident event: <input type="checkbox"/> U/K ____ Children, ages 0-18 ____ Adults
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E. INVESTIGATION INFORMATION

1. Death referred to: <input type="checkbox"/> Medical examiner <input type="checkbox"/> Coroner <input type="checkbox"/> Not referred <input type="checkbox"/> U/K	2. Person declaring official cause and manner of death: <input type="checkbox"/> Medical examiner <input type="checkbox"/> Mortician <input type="checkbox"/> Coroner <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Hospital physician <input type="checkbox"/> U/K <input type="checkbox"/> Other physician	3. Autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, conducted by: <input type="checkbox"/> Forensic pathologist <input type="checkbox"/> Other physician <input type="checkbox"/> Pediatric pathologist <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> General pathologist <input type="checkbox"/> Unknown pathologist <input type="checkbox"/> U/K If no, why not (e.g. parent or caregiver objected)? _____
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If autopsy performed, was a specialist consulted during autopsy (cardiac, neurology, etc.)? Yes No U/K If yes, specify specialist: _____

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy: Imaging: <input type="checkbox"/> X-ray - single <input type="checkbox"/> X-ray - multiple views <input type="checkbox"/> X-ray - complete skeletal series <input type="checkbox"/> CT scan <input type="checkbox"/> MRI <input type="checkbox"/> Photography of the brain External Exam: <input type="checkbox"/> Exam of general appearance <input type="checkbox"/> Head circumference Gross Examination of: <input type="checkbox"/> Body cavities <input type="checkbox"/> Brain <input type="checkbox"/> Endocrine organs <input type="checkbox"/> Gastrointestinal tract <input type="checkbox"/> Heart <input type="checkbox"/> Kidneys <input type="checkbox"/> Liver	Gross Examination continued: <input type="checkbox"/> Lungs <input type="checkbox"/> Neck structures <input type="checkbox"/> Pancreas <input type="checkbox"/> Spleen <input type="checkbox"/> Thymus In situ exam with removal & dissection of: <input type="checkbox"/> Brain <input type="checkbox"/> Endocrine organs <input type="checkbox"/> Gastrointestinal tract <input type="checkbox"/> Heart <input type="checkbox"/> Kidneys <input type="checkbox"/> Liver <input type="checkbox"/> Lungs <input type="checkbox"/> Neck structures <input type="checkbox"/> Pancreas <input type="checkbox"/> Spleen <input type="checkbox"/> Thymus	Weights of the: <input type="checkbox"/> Brain <input type="checkbox"/> Heart <input type="checkbox"/> Kidneys <input type="checkbox"/> Liver <input type="checkbox"/> Lungs <input type="checkbox"/> Neck structures <input type="checkbox"/> Pancreas <input type="checkbox"/> Spleen <input type="checkbox"/> Thymus
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4. Continued: Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Y	N	U/K	Abnormal?	Y	N	U/K	Abnormal?	Y	N	U/K	Abnormal?
Sampled tissue of:				Microscopic/Histological exam of:				Additional Testing:			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Airway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Airway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Cultures for infectious disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Bone or costochondral tissue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Bone or costochondral tissue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Microbiology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Brain or meninges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Brain or meninges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Postmortem metabolic screen
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Endocrine organs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Endocrine organs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Vitreous testing as an adjunct to other investigation results
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Gastrointestinal tract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gastrointestinal tract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Genetic testing
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart	Toxicology:			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Kidneys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kidneys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Toxicology If yes, check all that apply:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Liver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Negative <input type="checkbox"/> Opiates
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Lungs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Too high Rx drug, specify:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Neck structures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Neck structures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cocaine <input type="checkbox"/> Too high OTC drug, specify:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Pancreas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Marijuana <input type="checkbox"/> Other, specify:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Spleen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Methamphetamine <input type="checkbox"/> U/K
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Thymus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thymus				

5. 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

6. Describe any abnormalities checked in E4 or E5 or other significant findings noted in the autopsy: _____

7. Was there agreement between the cause of death listed on the pathology report and on the death certificate? Yes No U/K
 If no, describe the differences: _____

8. Was a death scene investigation performed? Yes No U/K
 If yes, which of the following death scene investigation components were completed?

Yes	No	U/K		Yes	No	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/>	<input type="radio"/>	If yes, shared with CDR team?

9. Agencies that conducted a scene investigation, check all that apply:

<input type="checkbox"/>	Medical examiner	<input type="checkbox"/>	Fire investigator
<input type="checkbox"/>	Coroner	<input type="checkbox"/>	EMS
<input type="checkbox"/>	ME investigator	<input type="checkbox"/>	Child Protective Services
<input type="checkbox"/>	Coroner investigator	<input type="checkbox"/>	Other, specify: _____
<input type="checkbox"/>	Law enforcement	<input type="checkbox"/>	U/K

10. Was a CPS record check conducted as a result of death? Yes No U/K

<p>11. Did any investigation find evidence of prior abuse? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, from what source? Check all that apply: <input type="checkbox"/> From x-rays <input type="checkbox"/> U/K <input type="checkbox"/> From autopsy <input type="checkbox"/> From CPS review <input type="checkbox"/> From law enforcement</p>	<p>12. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated</p> <p>If yes, services or actions resulting, 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"/> U/K</p>	<p>13. If death occurred in licensed setting (see D4), indicate action taken: <input type="radio"/> No action <input type="radio"/> License suspended <input type="radio"/> License revoked <input type="radio"/> Investigation ongoing <input type="radio"/> Other, specify: _____ <input type="radio"/> U/K</p>
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F. 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 F2 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: <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K If Homicide: <u>Yes</u> Child abuse? <input type="checkbox"/> Child neglect? <input type="checkbox"/> Complete Section I, Acts of Omission or Commission If Suicide: Complete Section I, Acts of Omission or Commission	6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.
	<input type="radio"/> From an injury (external cause). Select one and answer F4: <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G5 <input type="radio"/> Animal bite or attack, go to G6 <input type="radio"/> Fall or crush, go to G7 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G8 <input type="radio"/> Exposure, go to G9 <input type="radio"/> Undetermined, go to H1 <input type="radio"/> Other cause, go to G11 <input type="radio"/> U/K, go to H1
	<input type="radio"/> From a medical cause. Select one: <input type="radio"/> Asthma, go to G10 <input type="radio"/> Cancer, specify and go to G10 <input type="radio"/> Cardiovascular, specify and go to G10 <input type="radio"/> Congenital anomaly, specify and go to G10 <input type="radio"/> Diabetes, go to G10 <input type="radio"/> HIV/AIDS, go to G10 <input type="radio"/> Influenza, go to G10 <input type="radio"/> Low birth weight, go to G10 <input type="radio"/> Malnutrition/dehydration, go to G10 <input type="radio"/> Neurological/seizure disorder, go to G10 <input type="radio"/> Pneumonia, specify and go to G10 <input type="radio"/> Prematurity, go to G10 <input type="radio"/> SIDS, go to G10 <input type="radio"/> Other infection, specify and go to G10 <input type="radio"/> Other perinatal condition, specify and go to G10 <input type="radio"/> Other medical condition, specify and go to G10 <input type="radio"/> Undetermined, go to G10 <input type="radio"/> U/K, go to G10
	<input type="radio"/> Undetermined if injury or medical cause. go to H1 <input type="radio"/> U/K go to H1

G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident: Total number of vehicles: _____ <table border="0"> <tr> <th style="text-decoration: underline;">Child's</th> <th style="text-decoration: underline;">Other primary vehicle</th> <th></th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>None</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Car</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Van</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Sport utility vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Truck</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Semi/tractor trailer</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>RV</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>School bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Motorcycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Tractor</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other farm vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>All terrain vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Snowmobile</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Bicycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Train</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Subway</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Trolley</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	Child's	Other primary vehicle		<input type="radio"/>	<input type="radio"/>	None	<input type="radio"/>	<input type="radio"/>	Car	<input type="radio"/>	<input type="radio"/>	Van	<input type="radio"/>	<input type="radio"/>	Sport utility vehicle	<input type="radio"/>	<input type="radio"/>	Truck	<input type="radio"/>	<input type="radio"/>	Semi/tractor trailer	<input type="radio"/>	<input type="radio"/>	RV	<input type="radio"/>	<input type="radio"/>	School bus	<input type="radio"/>	<input type="radio"/>	Other bus	<input type="radio"/>	<input type="radio"/>	Motorcycle	<input type="radio"/>	<input type="radio"/>	Tractor	<input type="radio"/>	<input type="radio"/>	Other farm vehicle	<input type="radio"/>	<input type="radio"/>	All terrain vehicle	<input type="radio"/>	<input type="radio"/>	Snowmobile	<input type="radio"/>	<input type="radio"/>	Bicycle	<input type="radio"/>	<input type="radio"/>	Train	<input type="radio"/>	<input type="radio"/>	Subway	<input type="radio"/>	<input type="radio"/>	Trolley	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>	<input type="radio"/>	U/K	b. Position of child: <input type="radio"/> Driver <input type="radio"/> Passenger If passenger, relationship of driver to child: <table border="0"> <tr> <td><input type="radio"/> Front seat</td> <td><input type="radio"/> Biological parent</td> </tr> <tr> <td><input type="radio"/> Back seat</td> <td><input type="radio"/> Adoptive parent</td> </tr> <tr> <td><input type="radio"/> Truck bed</td> <td><input type="radio"/> Stepparent</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Foster parent</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Mother's partner</td> </tr> <tr> <td><input type="radio"/> On bicycle</td> <td><input type="radio"/> Father's partner</td> </tr> <tr> <td><input type="radio"/> Pedestrian</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Walking</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Boarding/blading</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table>	<input type="radio"/> Front seat	<input type="radio"/> Biological parent	<input type="radio"/> Back seat	<input type="radio"/> Adoptive parent	<input type="radio"/> Truck bed	<input type="radio"/> Stepparent	<input type="radio"/> Other, specify:	<input type="radio"/> Foster parent	<input type="radio"/> U/K	<input type="radio"/> Mother's partner	<input type="radio"/> On bicycle	<input type="radio"/> Father's partner	<input type="radio"/> Pedestrian	<input type="radio"/> Grandparent	<input type="radio"/> Walking	<input type="radio"/> Sibling	<input type="radio"/> Boarding/blading	<input type="radio"/> Other relative	<input type="radio"/> Other, specify:	<input type="radio"/> Friend	<input type="radio"/> U/K	<input type="radio"/> Other, specify:	<input type="radio"/> U/K	<input type="radio"/> U/K	c. Causes of incident, check all that apply: <table border="0"> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Back/front over</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Flipover</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Ran stop sign or red light</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Driver distraction</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Driver inexperience</td> <td><input type="checkbox"/> Animal in road</td> </tr> <tr> <td><input type="checkbox"/> Mechanical failure</td> <td><input type="checkbox"/> Cell phone use while driving</td> </tr> <tr> <td><input type="checkbox"/> Poor tires</td> <td><input type="checkbox"/> Racing, not authorized</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Drugs or alcohol use</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/sleeping</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical event, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Back/front over	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Flipover	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Animal in road	<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Cell phone use while driving	<input type="checkbox"/> Poor tires	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Poor weather	<input type="checkbox"/> Other driver error, specify:	<input type="checkbox"/> Poor visibility	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Drugs or alcohol use	<input type="checkbox"/> U/K	<input type="checkbox"/> Fatigue/sleeping		<input type="checkbox"/> Medical event, specify:	
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<input type="checkbox"/> Shoulder																																																																																																																			
<input type="checkbox"/> Sidewalk	<input type="checkbox"/> U/K																																																																																																																		

g. Drivers involved in incident, check all that apply:

Child as driver	Child's driver	Driver of other primary vehicle	Child as driver	Child's driver	Driver of other primary vehicle
	Age of Driver	Age of Driver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a graduated license
<input type="radio"/>	<input type="radio"/> <16 years	<input type="radio"/> <16 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license
<input type="radio"/>	<input type="radio"/> 16 to 18 years old	<input type="radio"/> 16 to 18 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license that has been restricted
<input type="radio"/>	<input type="radio"/> 19 to 21 years old	<input type="radio"/> 19 to 21 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a suspended license
<input type="radio"/>	<input type="radio"/> 22 to 29 years old	<input type="radio"/> 22 to 29 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> If recreational vehicle, has driver safety certificate
<input type="radio"/>	<input type="radio"/> 30 to 65 years old	<input type="radio"/> 30 to 65 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:
<input type="radio"/>	<input type="radio"/> >65 years old	<input type="radio"/> >65 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Was violating graduated licensing rules:
<input type="radio"/>	<input type="radio"/> U/K age	<input type="radio"/> U/K age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nighttime driving curfew
<input type="checkbox"/>	<input type="checkbox"/> Responsible for causing incident	<input type="checkbox"/> Responsible for causing incident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Passenger restrictions
<input type="checkbox"/>	<input type="checkbox"/> Was alcohol/drug impaired	<input type="checkbox"/> Was alcohol/drug impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Driving without required supervision
<input type="checkbox"/>	<input type="checkbox"/> Has no license	<input type="checkbox"/> Has no license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other violations, specify:
<input type="checkbox"/>	<input type="checkbox"/> Has a learner's permit	<input type="checkbox"/> Has a learner's permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K

h. Total number of occupants in vehicles:

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

i. Protective measures for child, Select one option per row:

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

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

2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:				b. Type of incident:		c. For fire, child died from:	
<input type="radio"/> Matches	<input type="radio"/> Heating stove	<input type="radio"/> Lightning	<input type="radio"/> Other explosives	<input type="radio"/> Fire, go to c		<input type="radio"/> Burns	
<input type="radio"/> Cigarette lighter	<input type="radio"/> Space heater	<input type="radio"/> Oxygen tank	<input type="radio"/> Appliance in water	<input type="radio"/> Scald, go to r		<input type="radio"/> Smoke inhalation	
<input type="radio"/> Utility lighter	<input type="radio"/> Furnace	<input type="radio"/> Hot cooking water	<input type="radio"/> Other, specify:	<input type="radio"/> Other burn, go to t		<input type="radio"/> Other, specify:	
<input type="radio"/> Cigarette or cigar	<input type="radio"/> Power line	<input type="radio"/> Hot bath water		<input type="radio"/> Electrocution, go to s			
<input type="radio"/> Candles	<input type="radio"/> Electrical outlet	<input type="radio"/> Other hot liquid, specify:		<input type="radio"/> Other, specify and go to t			
<input type="radio"/> Cooking stove	<input type="radio"/> Electrical wiring	<input type="radio"/> Fireworks	<input type="radio"/> U/K	<input type="radio"/> U/K, go to t		<input type="radio"/> U/K	

d. Material first ignited:	e. Type of building on fire:	f. Building's primary construction material:	g. Fire started by a person?	h. Did anyone attempt to put out fire?
<input type="radio"/> Upholstery	<input type="radio"/> N/A	<input type="radio"/> Wood	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Mattress	<input type="radio"/> Single home	<input type="radio"/> Steel	If yes, person's age _____	i. Did escape or rescue efforts worsen fire?
<input type="radio"/> Christmas tree	<input type="radio"/> Duplex	<input type="radio"/> Brick/stone	Does person have a history of setting fires?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Clothing	<input type="radio"/> Apartment	<input type="radio"/> Aluminum	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	j. Did any factors delay fire department arrival?
<input type="radio"/> Curtain	<input type="radio"/> Trailer/mobile home	<input type="radio"/> Other, specify:		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> U/K		If yes, specify:
<input type="radio"/> U/K	<input type="radio"/> U/K			

k. Were barriers preventing safe exit?	l. Was building a rental property?	m. Were building/rental codes violated?	n. Were proper working fire extinguishers present?
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
If yes, check all that apply:	o. Was sprinkler system present?	p. Were smoke detectors present?	
<input type="checkbox"/> Locked door	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<input type="checkbox"/> Window grate	If yes, was it working?	If yes, what type?	If yes, functioning properly?
<input type="checkbox"/> Locked window	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="checkbox"/> Removable batteries	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> Blocked stairway		<input type="checkbox"/> Non-removable batteries	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Hardwired	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
<input type="checkbox"/> U/K		<input type="checkbox"/> U/K	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
			If not functioning properly, reason:
			Missing batteries <input type="checkbox"/> Other <input type="checkbox"/> U/K <input type="checkbox"/>
			Other, specify: _____
			If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

<p>q. Suspected arson? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>r. For scald, was hot water heater set too high? <input type="radio"/> N/A <input type="radio"/> Yes, temp. setting: _____ <input type="radio"/> No <input type="radio"/> U/K</p>	<p>s. For electrocution, what cause: <input type="radio"/> Electrical storm <input type="radio"/> Faulty wiring <input type="radio"/> Wire/product in water <input type="radio"/> Child playing with outlet <input type="radio"/> Other, specify: <input type="radio"/> U/K</p>	<p>t. Other, describe in detail:</p>
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3. DROWNING

<p>a. Where was child last seen before drowning? Check all that apply:</p> <p><input type="checkbox"/> In water <input type="checkbox"/> In yard <input type="checkbox"/> On shore <input type="checkbox"/> In bathroom <input type="checkbox"/> On dock <input type="checkbox"/> In house <input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>	<p>b. What was child last seen doing before drowning?</p> <p><input type="radio"/> Playing <input type="radio"/> Tubing <input type="radio"/> Boating <input type="radio"/> Waterskiing <input type="radio"/> Swimming <input type="radio"/> Sleeping <input type="radio"/> Bathing <input type="radio"/> Other, specify: <input type="radio"/> Fishing <input type="radio"/> Surfing <input type="radio"/> U/K</p>	<p>c. Was child forcibly submerged? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>d. Drowning location: <input type="radio"/> Open water, go to e <input type="radio"/> U/K, go to n <input type="radio"/> Pool, hot tub, spa, go to i <input type="radio"/> Bathtub, go to w <input type="radio"/> Bucket, go to x <input type="radio"/> Well/cistern/septic, go to n <input type="radio"/> Toilet, go to z <input type="radio"/> Other, specify and go to n</p>	
<p>e. For open water, place: <input type="radio"/> Lake <input type="radio"/> Quarry <input type="radio"/> River <input type="radio"/> Gravel pit <input type="radio"/> Pond <input type="radio"/> Canal <input type="radio"/> Creek <input type="radio"/> U/K <input type="radio"/> Ocean</p>	<p>f. For open water, contributing environmental factors: <input type="radio"/> Weather <input type="radio"/> Drop off <input type="radio"/> Temperature <input type="radio"/> Rough waves <input type="radio"/> Current <input type="radio"/> Other, specify: <input type="radio"/> Riptide/undertow <input type="radio"/> U/K</p>	<p>g. If boating, type of boat: <input type="radio"/> Sailboat <input type="radio"/> Commercial <input type="radio"/> Jet ski <input type="radio"/> Other, specify: <input type="radio"/> Motorboat <input type="radio"/> Canoe <input type="radio"/> Kayak <input type="radio"/> U/K <input type="radio"/> Raft</p>	<p>h. For boating, was the child piloting boat? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	
<p>i. For pool, type of pool: <input type="radio"/> Above ground <input type="radio"/> In-ground <input type="radio"/> Hot tub, spa <input type="radio"/> Wading <input type="radio"/> U/K</p>	<p>j. For pool, child found: <input type="radio"/> In the pool/hot tub/spa <input type="radio"/> On or under the cover <input type="radio"/> U/K</p>	<p>k. For pool, ownership is: <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K</p>	<p>l. Length of time owners had pool/hot tub/spa: <input type="radio"/> N/A <input type="radio"/> >1yr <input type="radio"/> <6 months <input type="radio"/> U/K <input type="radio"/> 6m-1 yr</p>	
<p>m. Flotation device used? <input type="radio"/> N/A If yes, check all that apply: <input type="radio"/> Yes <input type="checkbox"/> Coast Guard approved <input type="checkbox"/> Not Coast Guard approved <input type="checkbox"/> U/K <input type="radio"/> No <input type="checkbox"/> Jacket <input type="checkbox"/> Cushion <input type="checkbox"/> Lifesaving ring <input type="radio"/> U/K If jacket: Correct size? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Worn correctly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Swim rings <input type="checkbox"/> Inner tube <input type="checkbox"/> Air mattress <input type="checkbox"/> Other, specify:</p>			<p>n. What barriers/layers of protection existed to prevent access to water? Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Alarm, go to r <input type="checkbox"/> Fence, go to o <input type="checkbox"/> Cover, go to s <input type="checkbox"/> Gate, go to p <input type="checkbox"/> U/K <input type="checkbox"/> Door, go to q</p>	
<p>o. Fence: Describe type: Fence height in ft _____ Fence surrounds water on: <input type="radio"/> Four sides <input type="radio"/> Two or <input type="radio"/> Three sides less sides <input type="radio"/> U/K</p>	<p>p. Gate, check all that apply: <input type="checkbox"/> Has self-closing latch <input type="checkbox"/> Has lock <input type="checkbox"/> Is a double gate <input type="checkbox"/> Opens to water <input type="checkbox"/> U/K</p>	<p>q. Door, check all that apply: <input type="checkbox"/> Patio door <input type="checkbox"/> Opens to water <input type="checkbox"/> Screen door <input type="checkbox"/> Barrier between <input type="checkbox"/> Steel door door and water <input type="checkbox"/> Self-closing <input type="checkbox"/> U/K <input type="checkbox"/> Has lock</p>	<p>r. Alarm, check all that apply: <input type="checkbox"/> Door <input type="checkbox"/> Window <input type="checkbox"/> Pool <input type="checkbox"/> Laser <input type="checkbox"/> U/K</p>	<p>s. Type of cover: <input type="radio"/> Hard <input type="radio"/> Soft <input type="radio"/> U/K</p>
<p>t. Local ordinance(s) regulating access to water? <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>	<p>u. How were layers of protection breached? Check all that apply: <input type="checkbox"/> No layers breached <input type="checkbox"/> Gap in fence <input type="checkbox"/> Door screen torn <input type="checkbox"/> Cover left off <input type="checkbox"/> Gate left open <input type="checkbox"/> Damaged fence <input type="checkbox"/> Door self-closer failed <input type="checkbox"/> Cover not locked <input type="checkbox"/> Gate unlocked <input type="checkbox"/> Fence too short <input type="checkbox"/> Window left open <input type="checkbox"/> Other, specify: <input type="checkbox"/> Gate latch failed <input type="checkbox"/> Door left open <input type="checkbox"/> Window screen torn <input type="checkbox"/> Gap in gate <input type="checkbox"/> Door unlocked <input type="checkbox"/> Alarm not working <input type="checkbox"/> Climbed fence <input type="checkbox"/> Door broken <input type="checkbox"/> Alarm not answered <input type="checkbox"/> U/K</p>			
<p>v. Child able to swim? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>w. For bathtub, child in a bathing aid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify type:</p>	<p>x. Warning sign or label posted? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>y. Lifeguard present? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	
<p>z. Rescue attempt made? <input type="radio"/> N/A If yes, who? Check all that apply: <input type="radio"/> Yes <input type="checkbox"/> Parent <input type="checkbox"/> Bystander <input type="radio"/> No <input type="checkbox"/> Other child <input type="checkbox"/> Other, specify: <input type="radio"/> U/K <input type="checkbox"/> Lifeguard <input type="checkbox"/> U/K</p>		<p>aa. Did rescuer(s) also drown? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, number of rescuers that drowned: _____</p>	<p>bb. Appropriate rescue equipment present? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	

4. ASPHYXIA

<p>a. Type of event:</p> <input type="radio"/> Suffocation, go to b <input type="radio"/> Strangulation, go to c <input type="radio"/> Choking, go to d <input type="radio"/> Other, specify and go to e <input type="radio"/> U/K, go to e	<p>b. If suffocation/asphyxia, action causing event:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)</td> <td><input type="radio"/> Confined in tight space</td> <td><input type="radio"/> Swaddled in tight blanket, but not sleep-related</td> </tr> <tr> <td><input type="radio"/> Covered in or fell into object, but not sleep-related</td> <td><input type="radio"/> Refrigerator/freezer</td> <td><input type="radio"/> Wedged into tight space, but not sleep-related</td> </tr> <tr> <td><input type="radio"/> Plastic bag</td> <td><input type="radio"/> Toy chest</td> <td><input type="radio"/> Asphyxia by gas, go to G8h</td> </tr> <tr> <td><input type="radio"/> Dirt/sand</td> <td><input type="radio"/> Automobile</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Trunk</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> U/K</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)	<input type="radio"/> Confined in tight space	<input type="radio"/> Swaddled in tight blanket, but not sleep-related	<input type="radio"/> Covered in or fell into object, but not sleep-related	<input type="radio"/> Refrigerator/freezer	<input type="radio"/> Wedged into tight space, but not sleep-related	<input type="radio"/> Plastic bag	<input type="radio"/> Toy chest	<input type="radio"/> Asphyxia by gas, go to G8h	<input type="radio"/> Dirt/sand	<input type="radio"/> Automobile	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> Trunk	<input type="radio"/> U/K	<input type="radio"/> U/K	<input type="radio"/> Other, specify:			<input type="radio"/> U/K			<input type="radio"/> Other, specify:			<input type="radio"/> U/K	
<input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)	<input type="radio"/> Confined in tight space	<input type="radio"/> Swaddled in tight blanket, but not sleep-related																										
<input type="radio"/> Covered in or fell into object, but not sleep-related	<input type="radio"/> Refrigerator/freezer	<input type="radio"/> Wedged into tight space, but not sleep-related																										
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<input type="radio"/> Dirt/sand	<input type="radio"/> Automobile	<input type="radio"/> Other, specify:																										
<input type="radio"/> Other, specify:	<input type="radio"/> Trunk	<input type="radio"/> U/K																										
<input type="radio"/> U/K	<input type="radio"/> Other, specify:																											
	<input type="radio"/> U/K																											
	<input type="radio"/> Other, specify:																											
	<input type="radio"/> U/K																											
<p>c. If strangulation, object causing event:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Clothing</td> <td><input type="radio"/> Leash</td> </tr> <tr> <td><input type="radio"/> Blind cord</td> <td><input type="radio"/> Electrical cord</td> </tr> <tr> <td><input type="radio"/> Car seat</td> <td><input type="radio"/> Person, go to G5q</td> </tr> <tr> <td><input type="radio"/> Stroller</td> <td><input type="radio"/> Automobile power window</td> </tr> <tr> <td><input type="radio"/> High chair</td> <td>or sunroof</td> </tr> <tr> <td><input type="radio"/> Belt</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Rope/string</td> <td><input type="radio"/> U/K</td> </tr> </table>	<input type="radio"/> Clothing	<input type="radio"/> Leash	<input type="radio"/> Blind cord	<input type="radio"/> Electrical cord	<input type="radio"/> Car seat	<input type="radio"/> Person, go to G5q	<input type="radio"/> Stroller	<input type="radio"/> Automobile power window	<input type="radio"/> High chair	or sunroof	<input type="radio"/> Belt	<input type="radio"/> Other, specify:	<input type="radio"/> Rope/string	<input type="radio"/> U/K	<p>d. If choking, object causing choking:</p> <input type="radio"/> Food, specify: <input type="radio"/> Toy, specify: <input type="radio"/> Balloon <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Was asphyxia an autoerotic event?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>g. History of seizures?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # ____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K											
<input type="radio"/> Clothing	<input type="radio"/> Leash																											
<input type="radio"/> Blind cord	<input type="radio"/> Electrical cord																											
<input type="radio"/> Car seat	<input type="radio"/> Person, go to G5q																											
<input type="radio"/> Stroller	<input type="radio"/> Automobile power window																											
<input type="radio"/> High chair	or sunroof																											
<input type="radio"/> Belt	<input type="radio"/> Other, specify:																											
<input type="radio"/> Rope/string	<input type="radio"/> U/K																											
		<p>f. Was child participating in 'choking game' or 'pass out game'?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>h. History of apnea?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # ____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																									
			<p>i. Was Heimlich Maneuver attempted?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																									

5. WEAPON, INCLUDING PERSON'S BODY PART

<p>a. Type of weapon:</p> <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m	<p>b. For firearms, type:</p> <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Firearm licensed?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Firearm safety features, check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Trigger lock</td> <td><input type="checkbox"/> Magazine disconnect</td> </tr> <tr> <td><input type="checkbox"/> Personalization device</td> <td><input type="checkbox"/> Minimum trigger pull</td> </tr> <tr> <td><input type="checkbox"/> External safety/drop safety</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Loaded chamber indicator</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Trigger lock	<input type="checkbox"/> Magazine disconnect	<input type="checkbox"/> Personalization device	<input type="checkbox"/> Minimum trigger pull	<input type="checkbox"/> External safety/drop safety	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Loaded chamber indicator	<input type="checkbox"/> U/K																																													
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<input type="checkbox"/> External safety/drop safety	<input type="checkbox"/> Other, specify:																																																							
<input type="checkbox"/> Loaded chamber indicator	<input type="checkbox"/> U/K																																																							
		<p>e. Where was firearm stored?</p> <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K	<p>f. Firearm stored with ammunition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																					
			<p>g. Firearm stored loaded?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																					
<p>h. Owner of fatal firearm:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> U/K, weapon stolen</td> <td><input type="radio"/> Grandparent</td> <td><input type="radio"/> Co-worker</td> </tr> <tr> <td><input type="radio"/> U/K, weapon found</td> <td><input type="radio"/> Sibling</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Self</td> <td><input type="radio"/> Spouse</td> <td><input type="radio"/> Neighbor</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Other relative</td> <td><input type="radio"/> Rival gang member</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Friend</td> <td><input type="radio"/> Stranger</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Acquaintance</td> <td><input type="radio"/> Law enforcement</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Child's boyfriend or girlfriend</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> Classmate</td> <td><input type="radio"/> U/K</td> </tr> </table>	<input type="radio"/> U/K, weapon stolen	<input type="radio"/> Grandparent	<input type="radio"/> Co-worker	<input type="radio"/> U/K, weapon found	<input type="radio"/> Sibling	<input type="radio"/> Institutional staff	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Neighbor	<input type="radio"/> Biological parent	<input type="radio"/> Other relative	<input type="radio"/> Rival gang member	<input type="radio"/> Adoptive parent	<input type="radio"/> Friend	<input type="radio"/> Stranger	<input type="radio"/> Stepparent	<input type="radio"/> Acquaintance	<input type="radio"/> Law enforcement	<input type="radio"/> Foster parent	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/> Other, specify:	<input type="radio"/> Mother's partner			<input type="radio"/> Father's partner	<input type="radio"/> Classmate	<input type="radio"/> U/K	<p>i. Sex of fatal firearm owner:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	<p>j. Type of sharp object:</p> <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>k. Type of blunt object:</p> <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K																										
<input type="radio"/> U/K, weapon stolen	<input type="radio"/> Grandparent	<input type="radio"/> Co-worker																																																						
<input type="radio"/> U/K, weapon found	<input type="radio"/> Sibling	<input type="radio"/> Institutional staff																																																						
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<input type="radio"/> Mother's partner																																																								
<input type="radio"/> Father's partner	<input type="radio"/> Classmate	<input type="radio"/> U/K																																																						
<p>l. What did person's body part do? Check all that apply:</p> <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>m. Did person using weapon have history of weapon-related offenses?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</p> <input type="radio"/> Yes, describe circumstances: <input type="radio"/> No <input type="radio"/> U/K	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width: 100%;"> <tr> <th colspan="2" style="text-align: left;"><u>Fatal and/or Other weapon</u></th> <th colspan="2" style="text-align: left;"><u>Fatal and/or Other weapon</u></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>		<u>Fatal and/or Other weapon</u>		<u>Fatal and/or Other weapon</u>		<input type="checkbox"/>	<input type="checkbox"/> Self	<input type="checkbox"/>	<input type="checkbox"/> Friend	<input type="checkbox"/>	<input type="checkbox"/> Biological parent	<input type="checkbox"/>	<input type="checkbox"/> Acquaintance	<input type="checkbox"/>	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/>	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/>	<input type="checkbox"/> Stepparent	<input type="checkbox"/>	<input type="checkbox"/> Classmate	<input type="checkbox"/>	<input type="checkbox"/> Foster parent	<input type="checkbox"/>	<input type="checkbox"/> Co-worker	<input type="checkbox"/>	<input type="checkbox"/> Mother's partner	<input type="checkbox"/>	<input type="checkbox"/> Institutional staff	<input type="checkbox"/>	<input type="checkbox"/> Father's partner	<input type="checkbox"/>	<input type="checkbox"/> Neighbor	<input type="checkbox"/>	<input type="checkbox"/> Grandparent	<input type="checkbox"/>	<input type="checkbox"/> Rival gang member	<input type="checkbox"/>	<input type="checkbox"/> Sibling	<input type="checkbox"/>	<input type="checkbox"/> Stranger	<input type="checkbox"/>	<input type="checkbox"/> Spouse	<input type="checkbox"/>	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/>	<input type="checkbox"/> Other relative	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:			<input type="checkbox"/>	<input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K <p>Other weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
<u>Fatal and/or Other weapon</u>		<u>Fatal and/or Other weapon</u>																																																						
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<input type="checkbox"/>	<input type="checkbox"/> Other relative	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:																																																					
		<input type="checkbox"/>	<input type="checkbox"/> U/K																																																					

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

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

6. ANIMAL BITE OR ATTACK

<p>a. Type of animal:</p> <input type="radio"/> Domesticated dog <input type="radio"/> Insect <input type="radio"/> Domesticated cat <input type="radio"/> Other, specify: <input type="radio"/> Snake <input type="radio"/> Wild mammal, specify: <input type="radio"/> U/K	<p>b. Animal access to child, check all that apply:</p> <input type="checkbox"/> Animal on leash <input type="checkbox"/> Animal escaped from cage or leash <input type="checkbox"/> Animal caged or inside fence <input type="checkbox"/> Animal not caged or leashed <input type="radio"/> Child reached in <input type="checkbox"/> U/K <input type="radio"/> Child entered animal area <input type="radio"/> U/K	<p>c. Did child provoke animal?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how?
		<p>d. Animal has history of biting or attacking?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

7. FALL OR CRUSH

<p>a. Type:</p> <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	<p>b. Height of fall:</p> _____ feet _____ inches <input type="checkbox"/> U/K	<p>c. Child fell from:</p> <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		
<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Grass <input type="radio"/> Gravel <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> Linoleum/vinyl <input type="radio"/> Marble/tile <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Barrier in place:</p> Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Screen <input type="checkbox"/> Other window guard <input type="checkbox"/> Fence <input type="checkbox"/> Railing <input type="checkbox"/> Stairway <input type="checkbox"/> Gate <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Child in a baby walker?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>g. Was child pushed, dropped or thrown?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, go to G5q	<p>h. For crush, did child:</p> <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Dirt/sand <input type="radio"/> Television <input type="radio"/> Person, go to G5q <input type="radio"/> Furniture <input type="radio"/> Commercial equipment <input type="radio"/> Walls <input type="radio"/> Farm equipment <input type="radio"/> Playground equipment <input type="radio"/> Other, specify: <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> U/K <input type="radio"/> Boulders/rocks

8. POISONING, OVERDOSE OR ACUTE INTOXICATION

<p>a. Type of substance involved, check all that apply:</p> <table border="0"> <tr> <td> <u>Prescription drug</u> <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify: </td> <td> <u>Over-the-counter drug</u> <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products </td> <td> <u>Cleaning substances</u> <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify: </td> <td> <u>Other substances</u> <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to f <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify: </td> <td><input type="checkbox"/> U/K</td> </tr> </table>						<u>Prescription drug</u> <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify:	<u>Over-the-counter drug</u> <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products	<u>Cleaning substances</u> <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify:	<u>Other substances</u> <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to f <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K
<u>Prescription drug</u> <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify:	<u>Over-the-counter drug</u> <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products	<u>Cleaning substances</u> <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify:	<u>Other substances</u> <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to f <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K						
<p>b. Where was the substance stored?</p> <input type="radio"/> Open area <input type="radio"/> Open cabinet <input type="radio"/> Closed cabinet, unlocked <input type="radio"/> Closed cabinet, locked <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Was the product in its original container?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Did container have a child safety cap?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>e. If prescription, was it child's?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>f. Was the incident the result of?</p> <input type="radio"/> Accidental overdose <input type="radio"/> Medical treatment mishap <input type="radio"/> Adverse effect, but not overdose <input type="radio"/> Deliberate poisoning <input type="radio"/> Acute intoxication <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>g. Was Poison Control called?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, who called: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Other caregiver <input type="radio"/> First responder <input type="radio"/> Medical person <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>h. For CO poisoning, was a CO detector present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many? _____ Functioning properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				

9. EXPOSURE

a. Circumstances, check all that apply: <input type="checkbox"/> Abandonment <input type="checkbox"/> Left in car <input type="checkbox"/> Left in room <input type="checkbox"/> Submerged in water <input type="checkbox"/> Injured outdoors <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Illegal border crossing <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	b. Condition of exposure: <input type="radio"/> Hyperthermia <input type="radio"/> Hypothermia <input type="radio"/> U/K _____ Ambient temp, degrees F	c. Number of hours exposed: _____ <input type="checkbox"/> U/K	d. Was child wearing appropriate clothing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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10. MEDICAL CONDITION

a. How long did the child have the medical condition? <input type="radio"/> In utero <input type="radio"/> Since birth <input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years <input type="radio"/> U/K	b. Was death expected as a result of the medical condition? <input type="radio"/> N/A not previously diagnosed <input type="radio"/> Yes <input type="checkbox"/> But at a later date <input type="radio"/> No <input type="radio"/> U/K	c. Was child receiving health care for the medical condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, within 48 hours of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Were the prescribed care plans appropriate for the medical condition? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K
e. Was child/family compliant with the prescribed care plans? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, what wasn't compliant? Check all that apply.		f. Was child up to date with American Academy of Pediatrics immunization schedule? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K	g. Was the medical condition associated with an outbreak? <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> U/K
h. Was environmental tobacco exposure a contributing factor in death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	i. Were there access or compliance issues related to the death? <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"/> Language barriers <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Referrals not made <input type="checkbox"/> Caregiver unskilled in providing care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Caregiver unwilling to provide care <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Caregiver's partner would not allow care <input type="checkbox"/> No phone <input type="checkbox"/> Lack of child care <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cultural differences <input type="checkbox"/> Lack of family or social support <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Services not available <input type="checkbox"/> U/K		

11. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG

a. Was this death a homicide, suicide, overdose, injury with the external cause as the only and obvious cause of death or a death which was expected within 6 months due to terminal illness? Yes No U/K If yes, go to Section H2

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

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

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

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

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

Yes No U/K If yes, describe:

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

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

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

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

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

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

<u>Y</u>	<u>N</u>	<u>U/K</u>	<u>Deaths</u>	<u>Y</u>	<u>N</u>	<u>U/K</u>	<u>Symptoms</u>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sudden unexpected death before age 50	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Febrile seizures
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>Heart Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unexplained fainting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart condition/heart attack or stroke before age 50	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>Other Diagnoses</u>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Aortic aneurysm or aortic rupture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital deafness
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arrhythmia (fast or irregular heart rhythm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Connective tissue disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cardiomyopathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mitochondrial disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle disorder or muscular dystrophy
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>Neurologic Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thrombophilia (clotting disorder)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy or convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other diseases that are genetic or run in families, specify:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other neurologic disease				

If sudden unexpected death before age 50, describe (for example, SIDS, drowning, relative who died in single and/or unexplained motor vehicle accident (driver of car)):

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

Yes No U/K

If yes, describe what test and/or for what disease and results:

Was a gene mutation found?

Yes No U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?
 Yes No U/K
 If yes, describe:

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

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Missed doses of prescribed medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changed prescribed medications, describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

j. Was the child compliant with their prescribed medications?
 N/A Yes No U/K
 If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?
 Check all that apply:

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

If yes to any items above, describe:

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

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

If yes to physical activity, describe type of activity:
 At incident _____ Within 24 hours of incident _____

Other specify:
 At incident _____ Within 24 hours of incident _____

m. Was the child an athlete? N/A Yes No U/K
 If yes, type of sport: Competitive Recreational Unknown
 If competitive, did the child participate in the 6 months prior to death? Yes No U/K

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

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

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

o. If child age 12 or older, did the child receive a pre-participation exam for a sport?
 N/A Yes No U/K
 If yes:
 Was it done within a year prior to death? Yes No U/K
 Did the exam lead to restrictions for sports or otherwise? Yes No U/K
 If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

p. How old was the child when diagnosed with epilepsy/seizure disorder? Age 0 (infant) through 20 years: _____ <input type="checkbox"/> U/K	r. What type(s) of seizures did the child have? Check all that apply: <input type="checkbox"/> Non-convulsive <input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure) <input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure) <input type="checkbox"/> U/K	t. How many seizures did the child have in the year preceding death? <input type="radio"/> 0/never <input type="radio"/> 2 <input type="radio"/> More than 3 <input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> U/K
q. What were the underlying cause(s) of the child's seizures? Check all that apply: <input type="checkbox"/> Brain injury/trauma, specify: <input type="checkbox"/> Brain tumor <input type="checkbox"/> Genetic/chromosomal <input type="checkbox"/> Cerebrovascular <input type="checkbox"/> Mesial temporal sclerosis <input type="checkbox"/> Central nervous system infection <input type="checkbox"/> Idiopathic or cryptogenic <input type="checkbox"/> Degenerative process <input type="checkbox"/> Other acute illness or injury other than epilepsy <input type="checkbox"/> Developmental brain disorder <input type="checkbox"/> Other, specify: <input type="checkbox"/> Inborn error of metabolism <input type="checkbox"/> U/K	s. Describe the child's epilepsy/seizures. Check all that apply: <input type="checkbox"/> Last less than 30 minutes <input type="checkbox"/> Last more than 30 minutes (status epilepticus) <input type="checkbox"/> Occur in the presence of fever (febrile seizure) <input type="checkbox"/> Occur in the absence of fever <input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)	u. Did treatment for seizures include anti-epileptic drugs? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how many different types of anti-epilepsy drugs (AED) did the child take? <input type="radio"/> 1 <input type="radio"/> 4 <input type="radio"/> More than 6 <input type="radio"/> 2 <input type="radio"/> 5 <input type="radio"/> U/K <input type="radio"/> 3 <input type="radio"/> 6
		v. Was night surveillance used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? Yes, go to H2a No, go to H2s U/K, go to H2s

a. Incident sleep place:

<input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette	<input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch	<input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K
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If adult bed, what type?
 Twin
 Full
 Queen
 King
 Other, specify:
 U/K

If futon,
 Bed position
 Couch position
 U/K

b. Child put to sleep: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	c. Child found: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	e. Usual sleep position: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	f. Was there a crib, bassinette or port-a-crib in home for child? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
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d. Usual sleep place: <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Futon <input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <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 futon, <input type="radio"/> Bed position <input type="radio"/> U/K <input type="radio"/> Couch position	g. Child in a new or different environment than usual? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify: h. Child last placed to sleep with a pacifier? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K i. Child wrapped or swaddled in blanket? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:
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j. Child overheated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, outside temp ____ degrees F Check all that apply: <input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing	k. Child exposed to second hand smoke? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally
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l. Child's face when found: <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	m. Child's neck when found: <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> U/K	n. Child's airway: <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	If fully or partially obstructed, what was obstructed? <input type="checkbox"/> Nose <input type="checkbox"/> U/K <input type="checkbox"/> Mouth <input type="checkbox"/> Chest compressed
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o. Objects in child's sleep environment in relation to airway obstruction:										p. Caregiver/supervisor fell asleep while feeding child?				
If present , describe position of object:										If present , did object obstruct airway?				
Objects:	Present?			On top		Under		Next		Tangled				
	Yes	No	U/K	of child	child	to child	around child	U/K	Yes	No	U/K			
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="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"/>			
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"/>			
Boppy or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="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"/>			
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"/>			

s. Is there a scene re-creation photo available for upload? <input type="radio"/> Yes <input type="radio"/> No If yes, upload here. Only one photo allowed.	q. Child sleeping in the same room as caregiver/supervisor at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
Select photo that most describes child placement and relevant objects. Size must be less than 6 mb and in .jpg or .gif format.	r. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> With adult(s): # _____ #U/K Adult obese: <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="checkbox"/> With other children: # _____ #U/K Children's ages: _____ <input type="checkbox"/> With animal(s): # _____ #U/K Type(s) of animal: _____ <input type="checkbox"/> U/K

3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? Yes No, go to H4 U/K, go to H4

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"/> U/K <input type="radio"/> No, go to www.saferproducts.gov to report
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4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? Yes No U/K

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:	

I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

TYPE OF ACT

<p>1. Did any act(s) of omission or commission cause and/or contribute to the death?</p> <p><input type="radio"/> Yes <input type="radio"/> No, go to Section J <input type="radio"/> Probable <input type="radio"/> U/K, go to Section J</p> <p>If yes/probable, were the act(s) either or both? Check all that apply:</p> <p><input type="checkbox"/> The direct cause of death <input type="checkbox"/> The contributing cause of death</p>	<p>2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Poor/absent supervision, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child abuse, go to 3</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child neglect, go to 8</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other negligence, go to 9</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Assault, not child abuse, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Religious/cultural practices, go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Suicide, go to 27</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Medical misadventure, specify and go to 11</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other, specify and go to 10</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K, go to 10</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 10	<input type="radio"/>	<input type="radio"/> Child abuse, go to 3	<input type="radio"/>	<input type="radio"/> Child neglect, go to 8	<input type="radio"/>	<input type="radio"/> Other negligence, go to 9	<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 10	<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 10	<input type="radio"/>	<input type="radio"/> Suicide, go to 27	<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 11	<input type="radio"/>	<input type="radio"/> Other, specify and go to 10	<input type="radio"/>	<input type="radio"/> U/K, go to 10
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<p>3. Child abuse, type. Check all that apply and describe in narrative.</p> <p><input type="checkbox"/> Physical, go to 4 <input type="checkbox"/> Emotional, specify and go to 10 <input type="checkbox"/> Sexual, specify and go to 10 <input type="checkbox"/> U/K, go to 10</p>	<p>4. Type of physical abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to 5 <input type="checkbox"/> Chronic Battered Child Syndrome, go to 7 <input type="checkbox"/> Beating/kicking, go to 7 <input type="checkbox"/> Scalding or burning, go to 7 <input type="checkbox"/> Munchausen Syndrome by Proxy, go to 7 <input type="checkbox"/> Other, specify and go to 7 <input type="checkbox"/> U/K, go to 7</p>	<p>5. For abusive head trauma, were there retinal hemorrhages?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>7. Events(s) triggering physical abuse, check all that apply:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Crying <input type="checkbox"/> Toilet training <input type="checkbox"/> Disobedience <input type="checkbox"/> Feeding problems <input type="checkbox"/> Domestic argument <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>
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<p>8. Child neglect, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Failure to protect from hazards, specify:</td> <td><input type="checkbox"/> Failure to seek/follow treatment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Failure to provide necessities</td> <td><input type="checkbox"/> Emotional neglect, specify:</td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> Abandonment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Shelter</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Failure to protect from hazards, specify:	<input type="checkbox"/> Failure to seek/follow treatment, specify:	<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Emotional neglect, specify:	<input type="checkbox"/> Food	<input type="checkbox"/> Abandonment, specify:	<input type="checkbox"/> Shelter	<input type="checkbox"/> U/K	<input type="checkbox"/> Other, specify:		<p>9. Other negligence:</p> <p><input type="radio"/> Vehicular <input type="radio"/> Other, specify: <input type="radio"/> U/K</p>	<p>10. Was act(s) of omission/commission:</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Chronic with child</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Pattern in family or with perpetrator</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Isolated incident</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Chronic with child	<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/> Isolated incident	<input type="radio"/>	<input type="radio"/> U/K
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PERSON(S) RESPONSIBLE

<p>11. Is person the caregiver or supervisor in previous section?</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, caregiver one, go to 24</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, caregiver two, go to 24</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes, supervisor, go to 25</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 24	<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 24	<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 25	<input type="radio"/>	<input type="radio"/> No	<p>12. Primary person responsible for action(s) that caused and/or contributed to death: Select no more than one person for caused and one person for contributed.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Self, go to 24</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Grandparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Medical provider</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Biological parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Sibling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Institutional staff</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Adoptive parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other relative</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Babysitter</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Stepparent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Friend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Licensed child care worker</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Foster parent</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Acquaintance</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Other, specify:</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Mother's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Child's boyfriend or girlfriend</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Father's partner</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Stranger</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Self, go to 24	<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Medical provider	<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Institutional staff	<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative	<input type="radio"/>	<input type="radio"/> Babysitter	<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Licensed child care worker	<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger	<input type="radio"/>	<input type="radio"/>
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<p>13. Person's age in years:</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____ # Years</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	_____	_____ # Years	<input type="checkbox"/>	<input type="checkbox"/> U/K	<p>14. Person's sex:</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Male</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Female</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Male	<input type="radio"/>	<input type="radio"/> Female	<input type="radio"/>	<input type="radio"/> U/K	<p>15. Does person speak English?</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K	<p>16. Person on active military duty?</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Yes</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> U/K</td> </tr> </table> <p>If yes, specify branch:</p>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> U/K
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<p>17. Person have history of substance abuse?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>18. Person have history of child maltreatment as victim?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted</p>	<p>19. Person have history of child maltreatment as a perpetrator?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed</p>	<p>20. Person have disability or chronic illness?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental illness, was person receiving MH services?</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
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<p>21. Person have prior child deaths?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>22. Person have history of intimate partner violence?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>23. Person have delinquent/criminal history?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
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<p>24. At time of incident was person impaired?</p> <p><u>Caused</u> <u>Contributed</u></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><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p>	<p>25. Does person have, check all that apply:</p> <p><u>Caused</u> <u>Contributed</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>26. Legal outcomes in this death, check all that apply:</p> <p><u>Caused</u> <u>Contributed</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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FOR SUICIDE

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

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

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

<input type="checkbox"/> None known	<input type="checkbox"/> Suicide by friend or relative	<input type="checkbox"/> Physical abuse/assault	<input type="checkbox"/> Gambling problems
<input type="checkbox"/> Family discord	<input type="checkbox"/> Other death of friend or relative	<input type="checkbox"/> Rape/sexual abuse	<input type="checkbox"/> Involvement in cult activities
<input type="checkbox"/> Parents' divorce/separation	<input type="checkbox"/> Bullying as victim	<input type="checkbox"/> Problems with the law	<input type="checkbox"/> Involvement in computer or video games
<input type="checkbox"/> Argument with parents/caregivers	<input type="checkbox"/> Bullying as perpetrator	<input type="checkbox"/> Drugs/alcohol	<input type="checkbox"/> Involvement with the Internet, specify:
<input type="checkbox"/> Argument with boyfriend/girlfriend	<input type="checkbox"/> School failure	<input type="checkbox"/> Sexual orientation	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Breakup with boyfriend/girlfriend	<input type="checkbox"/> Move/new school	<input type="checkbox"/> Religious/cultural issues	<input type="checkbox"/> U/K
<input type="checkbox"/> Argument with other friends	<input type="checkbox"/> Other serious school problems	<input type="checkbox"/> Job problems	
<input type="checkbox"/> Rumor mongering	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Money problems	

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services:	<u>Provided</u>	<u>Offered but</u>	<u>Offered but</u>	<u>Should be</u>	<u>Needed but</u>		<u>CDR review</u>
Select one option per row:	<u>after death</u>	<u>refused</u>	<u>U/K if used</u>	<u>offered</u>	<u>not available</u>	<u>U/K</u>	<u>led to referral</u>
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Debriefing for professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Genetic counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

Mark this case to edit/add prevention actions at a later date

1. Could the death have been prevented? Yes, probably No, probably not Team could not determine
2. What specific recommendations and/or initiatives resulted from the review? Check all that apply: No recommendations made, go to Section L

	Current Action Stage			Type of Action		Level of Action			
	<u>Recommendation</u>	<u>Planning</u>	<u>Implementation</u>	<u>Short term</u>	<u>Long term</u>	<u>Local</u>	<u>State</u>	<u>National</u>	
Education	Media campaign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	School program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Community safety project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Provider education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Parent education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Public forum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency	New policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Revised policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	New program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	New services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Expanded services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Law	New law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Amended law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Enforcement of law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environment	Modify a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recall a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Modify a public space	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Modify a private space(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"/>
	Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:
- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> N/A, no strategies | <input type="checkbox"/> Mental health | <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Advocacy organization | <input type="checkbox"/> Other, specify: |
| <input type="checkbox"/> No one | <input type="checkbox"/> Schools | <input type="checkbox"/> Medical examiner | <input type="checkbox"/> Local community group | |
| <input type="checkbox"/> Health department | <input type="checkbox"/> Hospital | <input type="checkbox"/> Coroner | <input type="checkbox"/> New coalition/task force | |
| <input type="checkbox"/> Social services | <input type="checkbox"/> Other health care providers | <input type="checkbox"/> Elected official | <input type="checkbox"/> Youth group | <input type="checkbox"/> U/K |

L. THE REVIEW MEETING PROCESS

1. Date of first CDR meeting: _____
2. Number of CDR meetings for this case: _____
3. Is CDR complete? N/A Yes No

4. Agencies at CDR meeting, check all that apply:
- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Medical examiner/coroner | <input type="checkbox"/> CPS | <input type="checkbox"/> Other health care | <input type="checkbox"/> Mental health | <input type="checkbox"/> Military |
| <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Other social services | <input type="checkbox"/> Fire | <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Others, list: |
| <input type="checkbox"/> Prosecutor/district attorney | <input type="checkbox"/> Physician | <input type="checkbox"/> EMS | <input type="checkbox"/> Court | |
| <input type="checkbox"/> Public health | <input type="checkbox"/> Hospital | <input type="checkbox"/> Education | <input type="checkbox"/> Child advocate | |

<p>5. Were the following data sources available at the CDR meeting?</p> <p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> CDC's SUIDI Reporting Form <input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form <input type="checkbox"/> Birth certificate - full form <input type="checkbox"/> Death certificate <input type="checkbox"/> Child's medical records or clinical history, including vaccinations <input type="checkbox"/> Biological mother's obstetric and prenatal information <input type="checkbox"/> Newborn screening results <input type="checkbox"/> Law enforcement records <input type="checkbox"/> Social service records <input type="checkbox"/> Child protection agency records <input type="checkbox"/> EMS run sheet <input type="checkbox"/> Hospital records <input type="checkbox"/> Autopsy/pathology reports <input type="checkbox"/> Mental health records <input type="checkbox"/> School records <input type="checkbox"/> Substance abuse treatment records 	<p>6. Factors that prevented an effective CDR meeting, check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Confidentiality issues among members prevented full exchange of information <input type="checkbox"/> HIPAA regulations prevented access to or exchange of information <input type="checkbox"/> Inadequate investigation precluded having enough information for review <input type="checkbox"/> Team members did not bring adequate information to the meeting <input type="checkbox"/> Necessary team members were absent <input type="checkbox"/> Meeting was held too soon after death <input type="checkbox"/> Meeting was held too long after death <input type="checkbox"/> Records or information were needed from another locality in-state <input type="checkbox"/> Records or information were needed from another state <input type="checkbox"/> Team disagreement on circumstances <input type="checkbox"/> Other factors, specify:
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<p>7. CDR meeting outcomes, check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Review led to additional investigation <input type="checkbox"/> Team disagreed with official manner of death. What did team believe manner should be? <input type="checkbox"/> Team disagreed with official cause of death. What did team believe cause should be? <input type="checkbox"/> Because of the review, the official cause or manner of death was changed 	<ul style="list-style-type: none"> <input type="checkbox"/> Review led to the delivery of services <input type="checkbox"/> Review led to changes in agency policies or practices <input type="checkbox"/> Review led to prevention initiatives being implemented <p style="text-align: right;"> <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National </p>
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8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

M. SUID AND SDY CASE REGISTRY

1. Is this an SDY or SUID case? Yes No If no, go to Section N

<p>2. Did this case go to Advance Review for the SDY Case Registry?</p> <p><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, date of first Advance Review meeting:</p>	<p>3. Notes from Advance Review meeting:</p>
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4. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? Yes No U/K

<p>5. Was a specimen sent to the SDY Case Registry bio-repository?</p> <p><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>6. Did the family consent to the SDY Case Registry?</p> <p><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
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7. Categorization for SDY Case Registry (choose only one):

<input type="radio"/> Excluded from SDY Case Registry	<input type="radio"/> Explained cardiac	<input type="radio"/> Explained other	<input type="radio"/> Unexplained, SUDEP
<input type="radio"/> No autopsy or death scene investigation	<input type="radio"/> Explained neurological	<input type="radio"/> Unexplained, possible cardiac	<input type="radio"/> Unexplained infant death (under age 1)
<input type="radio"/> Incomplete case information	<input type="radio"/> Explained infant suffocation (under age 1)	<input type="radio"/> Unexplained, possible cardiac and SUDEP	<input type="radio"/> Unexplained child death (age 1 and over)

<p>8. Categorization for SUID Case Registry (choose only one):</p> <ul style="list-style-type: none"> <input type="radio"/> Excluded (other explained causes, not suffocation) <input type="radio"/> Unexplained: No autopsy or death scene investigation <input type="radio"/> Unexplained: Incomplete case information <input type="radio"/> Unexplained: No unsafe sleep factors <input type="radio"/> Unexplained: Unsafe sleep factors <input type="radio"/> Unexplained: Possible suffocation with unsafe sleep factors <input type="radio"/> Explained: Suffocation with unsafe sleep factors 	<p>If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Soft bedding <input type="checkbox"/> Wedging <input type="checkbox"/> Overlay <input type="checkbox"/> Other, specify:
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N. 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, 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?

O. 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



The development of this report tool was supported, in part, by Grant No. U49MC00225
from the Maternal and Child Health Bureau (Title V, Social Security Act),
Health Resources and Services Administration, Department of Health and Human Services
and with funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health
Data Entry: <https://cdrdata.org>
www.childdeathreview.org
For help, email: info@childdeathreview.org
1-800-656-2434