

**SUDDEN UNEXPLAINED INFANT DEATH  
INVESTIGATION REPORT FORM (SUIDIRF) 3.96**

Case number \_\_\_\_\_

Infant's full name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_  
 Home address \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_  
 City, state, zip \_\_\_\_\_ Ethnicity \_\_\_\_\_  
 County \_\_\_\_\_ SS# \_\_\_\_\_  
 Police complaint number \_\_\_\_\_ Police department \_\_\_\_\_

**I. CIRCUMSTANCES OF DEATH**

Action	Date	Time	By whom (person or agency)	Remarks
ME/C notified				Receipt by:
NOK notified				Person:
Scene visit				___ ME/C staff ___ Other agency ___ Not done
Scene address				
Condition of infant when found     ___ Dead (D)     ___ Unresponsive (U)     ___ In distress (I)     ___ NA (N)				
Sequence of events before death:				

Event	Date	Time	Location (street, city, state, county, zip code)	
Injury				
Discovery				
Arrival			Hospital:	Transport by:
Actual death			___ On scene (S)     ___ Emergency room (E)     ___ Inpatient (I) ___ En route or DOA (D)     ___ During surgery (O)	
Pronounced dead			By whom: License #:	Where:

Event	Date	Time	By whom (person)	Remarks
Infant placed				Place:
Known alive				Place:
Infant found				Place:
First response				Type:
EMS called				From where:
EMS response			Agency:	
Police response			Agency:	

Place of fatal event     Describe type of place:  
 \_\_\_ Witness in room or area (W) or \_\_\_ Unwitnessed (U)  
 \_\_\_ At own home (H) or \_\_\_ Away from home (A)  
 \_\_\_ Indoors (I) or \_\_\_ Outdoors (O)  
 \_\_\_ In vehicle (V) or \_\_\_ Not in vehicle (N)

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**II. BASIC MEDICAL INFORMATION**

Health care provider for infant:		Phone:		
Medical history	<input type="checkbox"/> Not investigated (X)	<input type="checkbox"/> Unk (U)	<input type="checkbox"/> No past problems (N)	<input type="checkbox"/> Medical problems (P)
Medical source	<input type="checkbox"/> Physician (P)	<input type="checkbox"/> Other health care provider (H)	<input type="checkbox"/> Other (O)	<input type="checkbox"/> None (N)
	<input type="checkbox"/> Medical records (M)	<input type="checkbox"/> Family (F)		
Specific infant medical history	Yes	No	Unk	Remarks
A. Problems during labor or delivery Birth hospital: Birth city and state:				
B. Maternal illness or complications during pregnancy Number of prenatal visits:				
C. Major birth defects				
D. Infant was one of multiple births (e.g., a twin) Birth weight: Gestational age at birth (weeks):				
E. Hospitalization of infant after initial discharge				
F. Emergency room visits in past 2 weeks				
G. Known allergies				
H. Growth and weight gain considered normal				
I. Exposure to contagious disease in past 2 weeks				
J. Illness in past 2 weeks				
K. Lethargy, crankiness, or excessive crying in past 48 hours				
L. Appetite changes in past 48 hours				
M. Vomiting or choking in past 48 hours				
N. Fever or excessive sweating in past 48 hours				
O. Diarrhea or stool changes in past 48 hours				
P. Infant has ever stopped breathing or turned blue				
Q. Infant was ever breast-fed				
R. Vaccinations in past 72 hours				
S. Infant injury or other condition not mentioned above				
T. Deceased siblings				
Diet in past 2 weeks included: <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Cow's milk <input type="checkbox"/> Solids Date and time of last meal: Content of last meal:				
Medication history <input type="checkbox"/> Not investigated (X) <input type="checkbox"/> Unk (U) <input type="checkbox"/> Rx (P) <input type="checkbox"/> OTC (O) <input type="checkbox"/> Home remedies (H) <input type="checkbox"/> None (N)				
Emergency medical treatment <input type="checkbox"/> None (N) <input type="checkbox"/> CPR (R) <input type="checkbox"/> Transfusion (T) <input type="checkbox"/> IV fluids (F) <input type="checkbox"/> Surgery (S)				
Medicine names and doses; if prescription, include Rx number, Rx date, and name of pharmacy:		Describe nature and duration of resuscitation and treatments used to revive infant:		Describe any known injuries or marks on infant created or observed during resuscitation or treatment:

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**III. HOUSEHOLD ENVIRONMENT**

Action	Yes	No	Unk	Remarks
A. House was visited				
B. Evidence of alcohol abuse				
C. Evidence of drug abuse				
D. Serious physical or mental illness in household				
E. Police have been called to home in past				
F. Prior contact with social services				
G. Documented history of child abuse				
H. Odors, fumes, or peeling paint in household				
I. Dampness, visible standing water, or mold growth				
J. Pets in household				
Type of dwelling:	Water source:		Number of bedrooms:	
Main language in home:	Estimated annual income:		On public assistance ___ Yes ___ No	
Number of adults (>18 years of age): ___ and children (<18 years of age): ___ living in household. Total = ___ people.				
Number of smokers in household:		Does usual caregiver smoke? ___ Yes ___ No ___ Unk		If yes, ___ cigarettes/day
Maternal information	Age:	___ Married (M) ___ Divorced (D)	Cohabiting w/partner:	Education
		___ Single (S) ___ Widowed (W)	___ Yes ___ No	(years):
				___ Employed (E) ___ Not employed (N)

**IV. INFANT AND ENVIRONMENT**

___ In crib (C) ___ In bed (B) ___ Other (O)	___ Sleeping alone (A) ___ Sleeping with others (O)	___ NA (N)	Temperature of area:
Body position when placed	___ Unk ___ Back ___ Stomach ___ Side ___ Other		
Body position when found	___ Unk ___ Back ___ Stomach ___ Side ___ Other		
Face position when found	___ Unk ___ To left ___ To right ___ Facedown ___ Face up ___ To side		
Nose or mouth was covered or obstructed	___ Unk ___ No ___ Yes		
Postmortem changes when found	___ Unk ___ None ___ Rigor ___ Lividity ___ Other		
Number of cover or blanket layers on infant: ___ Covers on infant (C) ___ Wrapped (W) ___ No covers (N)			
Sleeping or supporting surface:		Clothing:	
Other items in contact with infant:		Items in crib or immediate environment:	
Devices operating in room:		Cooling source in room: ___ On (+) ___ Central (C) ___ None (N) ___ Off (-) ___ Space (S)	Heat source in room: ___ On (+) ___ Central (C) ___ None (N) ___ Off (-) ___ Space (S)
<b>Item collected</b>	<b>Yes</b>	<b>No</b>	<b>Item collected</b>
Baby bottle			Apnea monitor
Formula			Medicines
Diaper			Pacifier
Clothing			Bedding
		Number of scene photos taken:	
		Other items collected:	

**V. INTERVIEW AND PROCEDURAL TRACKING**

Contact	Name	Date	Time	Phone	Relationship to infant
Mother					
Father					
Usual caregiver					
Last caregiver					
Placer					
Last witness					
Finder					
First responder					
EMS caller					
EMS responder					
Police					
Alternate contact person:				Phone:	
Action	Date	Time	Action		
Medical record review for infant			Doll reenactment performed ___ Yes ___ No		
Medical record review for mother			Scene diagram completed ___ Yes ___ No		
Physician or provider interview			Body diagram completed ___ Yes ___ No		
Referral to social or SIDS services			Detailed protocol completed ___ Yes ___ No ___ NA		
Cause of death discussed with family			Other:		

**VI. OVERALL PRELIMINARY SUMMARY**

Notes to pathologist performing autopsy:

Indications that an environmental hazard, drug, poison, or consumer product contributed to death \_\_\_ Yes \_\_\_ No

Organ or tissue donation requested by family or agency \_\_\_ Yes \_\_\_ No \_\_\_ Unk

Cause of death: \_\_\_ Presumed SIDS \_\_\_ Suspect trauma or injury \_\_\_ Other

**VII. CASE DISPOSITION**

Case disposition \_\_\_ Case declined (D) due to \_\_\_ Case accepted (J) for  
 \_\_\_ Topic (T) \_\_\_ Locale (L) \_\_\_ Autopsy (A) \_\_\_ Inspection (I) \_\_\_ Certification (C)

Body disposition \_\_\_ Brought in for exam (E) \_\_\_ Brought in for holding or claim (C) \_\_\_ Released from site (R)

Who will sign DC?

Transport agent:

Funeral home:

Investigator and affiliation:

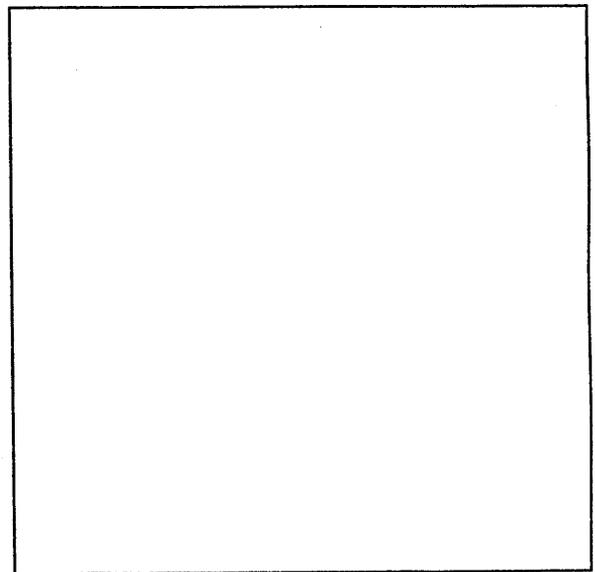
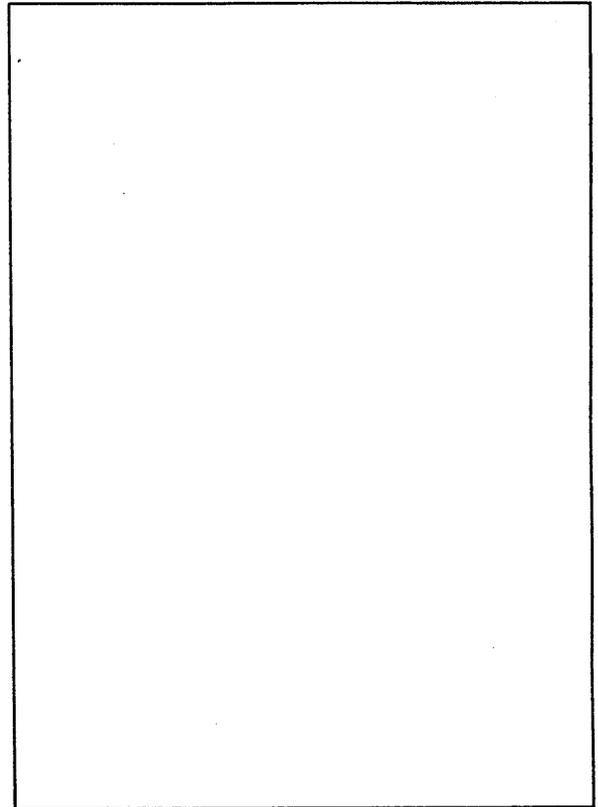
Date:

Number of supplement pages attached:

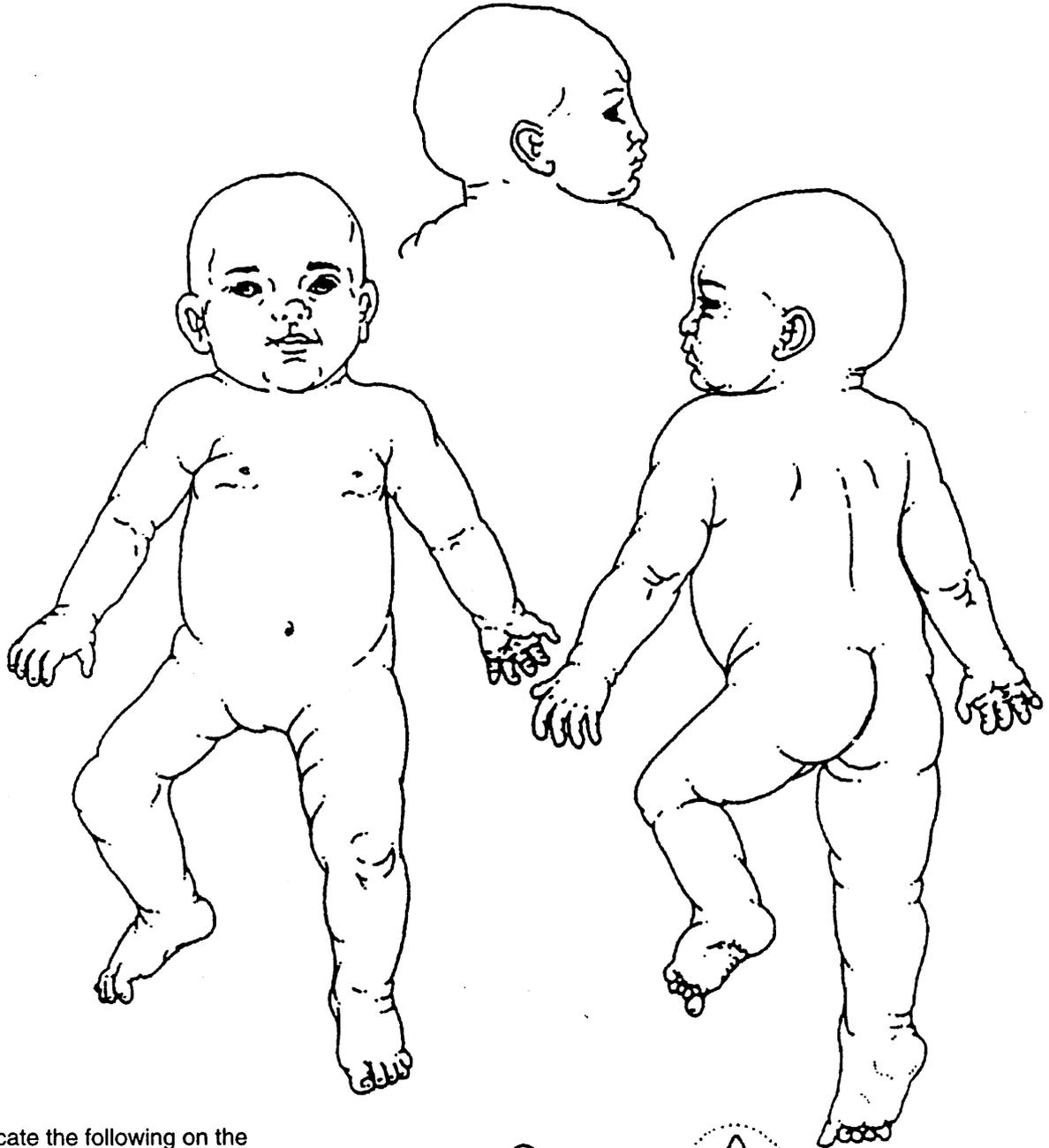
# SCENE DIAGRAM

**Instructions**

- 1) Use figure at right for a rectangular room, and use figure below right for a square room. Use a supplementary page to draw an unusually shaped room.
  
- 2) Indicate the following on the diagram (check when done):
  - North direction
  - Windows and doors
  - Wall lengths
  - Ceiling height: \_\_\_\_\_
  - Location of furniture
  - Location of crib or bed
  - Body location when found
  - Location of other objects in room
  - Location of heating and cooling supplies and returns
  
- 3) Make additional notes or drawings in available spaces as needed.
  
- 4) Check all that apply about heat source:
  - Gas furnace or boiler
  - Electric furnace or boiler
  - Forced air
  - Steam or hot water
  - Electric baseboard
  - Other: \_\_\_\_\_
  - None
  
- 5) Complete the following:
  - Thermostat setting: \_\_\_\_\_
  - Thermostat reading: \_\_\_\_\_
  - Actual room temperature: \_\_\_\_\_
  - Outside temperature: \_\_\_\_\_



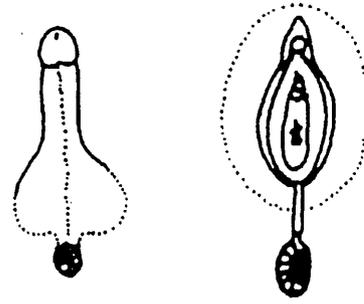
**BABY DIAGRAM**



**Instructions**

- 1) If present, indicate the following on the diagram. If not present, enter "None."
  - \_\_\_\_\_ Drainage or discharge from body or orifices
  - \_\_\_\_\_ Marks or bruises
  - \_\_\_\_\_ Location of diagnostic or therapeutic devices
  - \_\_\_\_\_ Pale pressure mark areas
  - \_\_\_\_\_ Predominate areas of lividity

- 2) Complete the following:
  - Body temperature: \_\_\_\_\_
  - Source of temperature: \_\_\_\_\_



**SUIDIRF SUPPLEMENT**