

## Infant Death Investigation Checklist

### Arizona Report Form, Version 1.0

CHILD		
Name:	SSN:	
Home Address:		
Incident Address:		
Date of Birth:	Date of Death:	Estimated Time of Death:

MOTHER OR CAREGIVER #1		
Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):	Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown		

FATHER OR CAREGIVER #2		
Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):	Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown		

CAREGIVER AT TIME OF DEATH (if other than parent)		
Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):	Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown		
Relationship to child:	How long cared for child:	

### CAREGIVER(S) AT TIME OF DEATH INFORMATION

1. Primary Caregiver Column 1: Secondary Caregiver Column 2: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%; text-align: center;">One</th> <th style="width: 10%; text-align: center;">Two</th> <th></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Biological parent</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Adoptive parent</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Step parent</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Foster parent</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mother's partner</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Father's partner</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Grandparent</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sibling</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other relative</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Friend/Neighbor</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Unknown</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Daycare Provider</td></tr> <tr><td></td><td><input type="checkbox"/></td><td>    <input type="checkbox"/> Licensed</td></tr> <tr><td></td><td><input type="checkbox"/></td><td>    <input type="checkbox"/> Unlicensed</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other Specify:</td></tr> </tbody> </table>	One	Two		<input type="checkbox"/>	<input type="checkbox"/>	Biological parent	<input type="checkbox"/>	<input type="checkbox"/>	Adoptive parent	<input type="checkbox"/>	<input type="checkbox"/>	Step parent	<input type="checkbox"/>	<input type="checkbox"/>	Foster parent	<input type="checkbox"/>	<input type="checkbox"/>	Mother's partner	<input type="checkbox"/>	<input type="checkbox"/>	Father's partner	<input type="checkbox"/>	<input type="checkbox"/>	Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	<input type="checkbox"/>	Other relative	<input type="checkbox"/>	<input type="checkbox"/>	Friend/Neighbor	<input type="checkbox"/>	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	<input type="checkbox"/>	Daycare Provider		<input type="checkbox"/>	<input type="checkbox"/> Licensed		<input type="checkbox"/>	<input type="checkbox"/> Unlicensed	<input type="checkbox"/>	<input type="checkbox"/>	Other Specify:	2. Caregiver(s) age in years One Two _____ # years <input type="checkbox"/> <input type="checkbox"/> Unknown <hr/> 3. Caregiver(s) Sex: One Two <input type="checkbox"/> <input type="checkbox"/> Male <input type="checkbox"/> <input type="checkbox"/> Female <input type="checkbox"/> <input type="checkbox"/> Unknown <hr/> 4. Caregiver(s) employment status: One Two <input type="checkbox"/> <input type="checkbox"/> Employed <input type="checkbox"/> <input type="checkbox"/> Unemployed <input type="checkbox"/> <input type="checkbox"/> On disability <input type="checkbox"/> <input type="checkbox"/> Stay-at-home <input type="checkbox"/> <input type="checkbox"/> Retired <input type="checkbox"/> <input type="checkbox"/> Unknown	5. Caregiver(s) substance use history One Two <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> Unknown If yes, check all that apply <input type="checkbox"/> <input type="checkbox"/> Alcohol <input type="checkbox"/> <input type="checkbox"/> Cocaine <input type="checkbox"/> <input type="checkbox"/> Marijuana <input type="checkbox"/> <input type="checkbox"/> Methamphetamine <input type="checkbox"/> <input type="checkbox"/> Opiates <input type="checkbox"/> <input type="checkbox"/> Prescriptions <input type="checkbox"/> <input type="checkbox"/> Over the counter <input type="checkbox"/> <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> Other, Specify:	6. Caregiver(s) have prior child death: One Two <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> Unknown If yes, cause(s) Check all that apply <input type="checkbox"/> <input type="checkbox"/> Abuse # _____ <input type="checkbox"/> <input type="checkbox"/> Neglect # _____ <input type="checkbox"/> <input type="checkbox"/> Accident # _____ <input type="checkbox"/> <input type="checkbox"/> Suicide # _____ <input type="checkbox"/> <input type="checkbox"/> SIDS # _____ <input type="checkbox"/> <input type="checkbox"/> Unknown # _____ <input type="checkbox"/> <input type="checkbox"/> Other # _____
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#### MEDICAL EXAMINERS OFFICE FAX NUMBERS

Apache (520) 243-8610	Maricopa (602) 506-1546
Cochise (520) 452-1011	Mohave (928) 505-5889
Coconino (928) 679-8798	Navajo (520) 243-8610
Gila North/South (520) 243-8610	Pima (520) 243-8610
Graham (520) 243-8610	Pinal (520) 243-8610
Greenlee (520) 243-8610	Santa Cruz (520) 243-8610
La Paz (520) 243-8610	Yavapai (928) 771-3504
	Yuma (928) 336-7319

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## Arizona Report Form, Version 1.0

Mail or fax completed forms to:  
 County Office of the Medical Examiner  
 (fax numbers at the bottom of page 1)  
 Arizona Department of Health Services  
 (fax: 602-542-1843)

<b>Incident State:</b> <input type="checkbox"/> Arizona <input type="checkbox"/> Other, Specify	<b>Was 911 or local emergency number called?</b> <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<b>CPR performed before EMS arrived?</b> <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<b>During resuscitation was child:</b> <input type="checkbox"/> Injured <input type="checkbox"/> Shaken <input type="checkbox"/> Jostled <input type="checkbox"/> Other, specify:	<b>EMS responded to scene?</b> <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<b>Child's activity at time of incident, check all that apply:</b> <input type="checkbox"/> Sleeping <input type="checkbox"/> Playing <input type="checkbox"/> Working <input type="checkbox"/> Eating <input type="checkbox"/> In vehicle <input type="checkbox"/> Unknown <input type="checkbox"/> Other Specify:	<b>Total number of deaths at incident event:</b>  Children (Ages 0-18):  Adults: <input type="checkbox"/> Unknown
<b>Incident County:</b>						

**What led someone to check on the infant?**

**Who was in the home when the child was found?**

<b>Describe child's appearance when found:</b>	<b>No</b>	<b>Yes</b>	<b>Unknown</b>	<b>Describe/specify location:</b>	<b>First Assessed by:</b>
Discoloration around face/nose/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> EMS
Secretions (foam, froth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> ER
Skin discoloration (livor mortis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> PD
Pressure marks (pale areas, blanching)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Marks on body (scratches or bruises)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Infant moved prior to being found	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Time frame information:</b>					
Time Found	Last Seen Alive	Time Police Called	Call Type	<input type="checkbox"/> 911	<input type="checkbox"/> Regular
Last Feeding Time			Person Calling	<input type="checkbox"/> Other, specify: _____	

**What did the child feel like when found? (check all that apply)**

<input type="checkbox"/> Sweaty	<input type="checkbox"/> Warm to touch	<input type="checkbox"/> Cool to touch	Surface body temperature:
<input type="checkbox"/> Limp, flexible	<input type="checkbox"/> Rigid, stiff	<input type="checkbox"/> Unknown	Temperature at hospital:
<input type="checkbox"/> Other, Specify: _____			

**SUFFOCATION/ASPHYXIA**

<b>A. Type of Event</b> <input type="checkbox"/> Suffocation, go to B.  <input type="checkbox"/> Strangulation, go to C.  <input type="checkbox"/> Choking, go to D.	<b>B. If suffocation/asphyxia, action causing event:</b> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Sleep-related (e.g. bedding, overlay, wedged)</td> <td><input type="checkbox"/> Confined in tight space</td> <td><input type="checkbox"/> Swaddled in tight blanket, not sleep related</td> </tr> <tr> <td><input type="checkbox"/> Covered in or fell into object, not sleep related</td> <td><input type="checkbox"/> Refrigerator/freezer</td> <td><input type="checkbox"/> Wedged into tight space, but not sleep related</td> </tr> <tr> <td><input type="checkbox"/> Plastic bag</td> <td><input type="checkbox"/> Toy chest</td> <td><input type="checkbox"/> Asphyxia by gas</td> </tr> <tr> <td><input type="checkbox"/> Dirt/Sand</td> <td><input type="checkbox"/> Automobile</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Unknown</td> <td><input type="checkbox"/> Trunk</td> <td><input type="checkbox"/> Other, Specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Other, Specify: _____</td> <td><input type="checkbox"/> Unknown</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other, Specify: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Sleep-related (e.g. bedding, overlay, wedged)	<input type="checkbox"/> Confined in tight space	<input type="checkbox"/> Swaddled in tight blanket, not sleep related	<input type="checkbox"/> Covered in or fell into object, not sleep related	<input type="checkbox"/> Refrigerator/freezer	<input type="checkbox"/> Wedged into tight space, but not sleep related	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Toy chest	<input type="checkbox"/> Asphyxia by gas	<input type="checkbox"/> Dirt/Sand	<input type="checkbox"/> Automobile	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Trunk	<input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/> Unknown			<input type="checkbox"/> Other, Specify: _____	
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<input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/> Unknown																					
	<input type="checkbox"/> Other, Specify: _____																					

<b>C. If strangulation, object causing event:</b> <input type="checkbox"/> Clothing <input type="checkbox"/> Blind cord <input type="checkbox"/> Car seat <input type="checkbox"/> Stroller <input type="checkbox"/> High chair <input type="checkbox"/> Belt <input type="checkbox"/> Rope/string <input type="checkbox"/> Leash <input type="checkbox"/> Electrical cord <input type="checkbox"/> Automobile power window or sunroof <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<b>D. If choking, object causing choking:</b> <input type="checkbox"/> Food, Specify: _____ <input type="checkbox"/> Toy, Specify: _____ <input type="checkbox"/> Balloon <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Unknown
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**OTHER CIRCUMSTANCES OF INCIDENT – ANSWER RELEVANT SECTIONS**

<b>DID DEATH OCCUR WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT?</b>				<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>A. INCIDENT sleep place:</b> <input type="checkbox"/> Crib <input type="checkbox"/> Bassinette <input type="checkbox"/> Adult bed <input type="checkbox"/> Waterbed <input type="checkbox"/> Playpen <input type="checkbox"/> Couch <input type="checkbox"/> Chair <input type="checkbox"/> Floor <input type="checkbox"/> Car seat/Stroller <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<b>If adult bed, What type?</b> <input type="checkbox"/> Twin <input type="checkbox"/> Full <input type="checkbox"/> Queen <input type="checkbox"/> King <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<b>C. Child put to sleep:</b> <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown By Whom: _____	<b>D. Child found:</b> <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown By Whom: _____		
<b>E. Was there a crib, bassinette, or port-a-crib in home for child?</b>		<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	
<b>F. USUAL sleep place:</b> <input type="checkbox"/> Crib <input type="checkbox"/> Bassinette <input type="checkbox"/> Adult bed <input type="checkbox"/> Waterbed <input type="checkbox"/> Playpen <input type="checkbox"/> Couch <input type="checkbox"/> Chair <input type="checkbox"/> Floor <input type="checkbox"/> Car seat/Stroller <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<b>If adult bed, what type?</b> <input type="checkbox"/> Twin <input type="checkbox"/> Full <input type="checkbox"/> Queen <input type="checkbox"/> King <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<b>G. USUAL sleep position:</b> <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown	<b>H. Child in new or different environment?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		



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#### HEALTH INFORMATION

<b>Child's Primary Care Physician:</b>		<b>Phone:</b> (    )	<b>Last Visit: When?</b>	<b>Why:</b>
<b>Allergies:</b>		<b>Birth defects:</b>		
<b>Medications:</b>				
Has the child been immunized? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		Date of last immunization:		
Immunizations current? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If immunized within the last 30 days, specify type:				
Does the child use any home monitors? <input type="checkbox"/> No <input type="checkbox"/> Yes Type/Brand:				
If Yes, was child on home monitor at time of death? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Anyone else in household or other contacts (e.g. daycare) recently ill? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Family history of genetic/inheritable disease(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:				

#### BIRTH INFORMATION

<b>Birth place (home, hospital name and location):</b>				
Birth complications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify:				
<b>Gestational Age</b> <input type="checkbox"/> Unknown _____ weeks	<b>Birth Weight:</b> <input type="checkbox"/> Unknown _____ grams _____ pounds/ounces	<b>Multiple Birth?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, # _____	<b># of prenatal visits</b> <input type="checkbox"/> Unknown # _____	<b>Month of first prenatal visit</b> Specify 1-9: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None

<b>During pregnancy, did mother (check all that apply):</b>				
<input type="checkbox"/> Smoke tobacco	<input type="checkbox"/> Experience intimate partner violence	<input type="checkbox"/> Heavy alcohol use	<input type="checkbox"/> Misuse OTC or prescription drugs	
<input type="checkbox"/> Use illicit drugs	<input type="checkbox"/> Child born drug exposed	<input type="checkbox"/> Child born with fetal alcohol effects or syndrome		
<input type="checkbox"/> During pregnancy, did mother have medical complications/infections? (check all that apply) Specify type, if known				
<input type="checkbox"/> Lung Disease	<u>Type</u>	<input type="checkbox"/> Preterm Labor	<u>Type</u>	
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Premature Rupture Membrane	_____	
<input type="checkbox"/> Blood Disorder	_____	<input type="checkbox"/> Vaginal Bleeding	_____	
<input type="checkbox"/> Infectious Disease	_____	<input type="checkbox"/> Diabetes Mellitus	_____	
<input type="checkbox"/> Familial Genetic Disorder	_____	<input type="checkbox"/> Other	_____	
<b>Were there access or compliance issues related to prenatal care?</b>				
<input type="checkbox"/> No	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Religious objections to care		
<input type="checkbox"/> Yes	<input type="checkbox"/> Limited or no health insurance coverage	<input type="checkbox"/> Cultural differences		
If yes, check all that apply:				
<input type="checkbox"/> Unknown	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Unwilling to obtain care		
	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Did not know care needed		
	<input type="checkbox"/> No phone	<input type="checkbox"/> Other, specify:		

#### SCENE DOCUMENTATION

<b>Photos of Death Scene Taken?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Property Seized?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>What Agency Seized Property?</b>		
<b>Formula?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Bottles/Contents?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Bedding?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Crib?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Other, Specify:</b>				
Was there an open CPS case with child at time of death?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unk		
Was the child ever placed outside of the home prior to death?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date of Placement:		
Were any siblings placed outside of the home prior to this child's death?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date of Placement:		

#### PERSON COMPLETING FORM

<b>Name (please print or type):</b>		
<b>Agency:</b>		
<b>Telephone:</b> (    )	<b>Fax:</b> (    )	<b>Date:</b>
<b>Signature:</b>	<b>Date Signed:</b>	

**ADDITIONAL COMMENTS:** (Include information about additional caregivers/supervisors or circumstances. Attach additional pages as necessary)