



### Contents

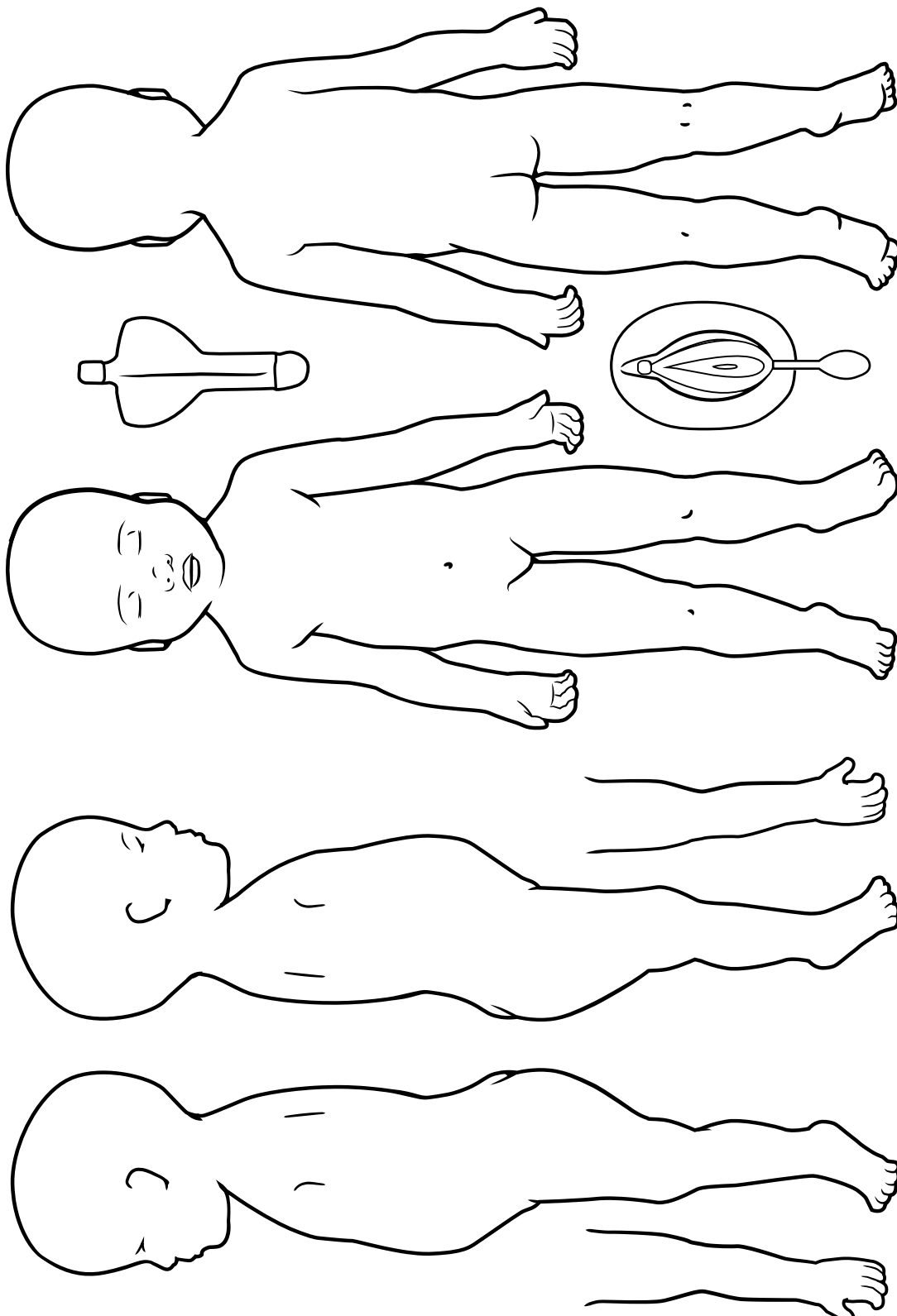
- A. Body Diagram . . . . . 2
- B. Emergency Medical Services (EMS) Interview . . . . . 3
- C. Hospital Interview . . . . . 5
- D. Immunization Record . . . . . 7
- E. Infant Exposure History . . . . . 8
- F. Informant Contact. . . . . 10
- G. Law Enforcement Interview . . . . . 11
- H. Material Collections - Log . . . . . 13
- I. Nonprofessional Responder Interview . . . . . 16
- J. Parental Information . . . . . 17
- K. Primary Residence Investigation . . . . . 19

## A. Body Diagram

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

*Note visible injuries, livor mortis, or rigor mortis.*



## B. Emergency Medical Services (EMS) Interview

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. EMS responder's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

3. EMS responder's agency: \_\_\_\_\_

4. What date and time was EMS dispatched? Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

### 5. Information about the person who called 911.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Relationship to infant: (e.g., aunt) \_\_\_\_\_

6. What date and time did EMS arrive at the scene? Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

7. Was anyone doing CPR when EMS arrived at the scene? Yes No  
If yes, who? \_\_\_\_\_

8. Where was the infant when EMS arrived at the scene? (e.g., crib, arms of caregiver)  
\_\_\_\_\_

### 9. Describe infant's appearance when found by EMS. (indicate all that apply)

Appearance	Present?			Describe and specify location
Discoloration around face, nose, or mouth	Yes	No	Unknown	
Secretions or fluids (e.g., foam, froth, or urine)	Yes	No	Unknown	
Skin discoloration (e.g., livor mortis, pale areas, darkness, or color changes)	Yes	No	Unknown	
Pressure marks (e.g., pale areas, or blanching)	Yes	No	Unknown	
Rash or petechiae (e.g., small, red blood spots on skin, membrane, or eyes)	Yes	No	Unknown	
Marks on body (e.g., scratches or bruises)	Yes	No	Unknown	
Other: _____	Yes	No	Unknown	

### 10. How did the infant feel when found by EMS? (check all that apply)

Sweaty Warm to touch Cool to touch Limp/flexible Rigid/stiff Unknown

Other, specify: \_\_\_\_\_

### 11. Did EMS administer resuscitative efforts? Yes No Unknown

If yes, which of the following were done? CPR IV/IO access Gastric tube Infant immobilized  
Medications Intubation Electric shock Other, specify:

If no – Skip to No. 16 on next page.

**12. List all emergency medications given to the infant.**

Name of emergency medication	Dose	Route	Military time

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

**14. Describe any injuries sustained by infant during resuscitative efforts. (if any)**

---

**15. What date and time were the resuscitative efforts terminated?**

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_ Not terminated by EMS

**16. Name of the authorizing medical control physician who pronounced death.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**17. Authorizing medical control physician's agency:** \_\_\_\_\_

**18. What was the final disposition of the infant?**

Left at the scene      Released to funeral home      Morgue      ME/C facility  
 Transported to the hospital, specify: \_\_\_\_\_ Other, specify: \_\_\_\_\_

**19. Name of the person who received the infant.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**20. Describe the reaction of the caregiver(s) to the infant's death.**

**21. Were there any additional comments from the EMS personnel? (describe concerns with scene or what happened)**

**Investigator's Notes**

**1. Indicate the task(s) performed.**      EMS run report/sheet      911 tape

**2. Name of the person who completed this section.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**3. What date and time was this section completed?**

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

**4. How was the interview conducted?**      In person      Telephone      Other, specify: \_\_\_\_\_

## C. Hospital Interview

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. What date and time did the infant arrive at the hospital?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

### 3. Hospital name: \_\_\_\_\_

### 4. Hospital address: \_\_\_\_\_

### 5. Name and phone number of the physician responsible for treatment at hospital.

Last: \_\_\_\_\_ First: \_\_\_\_\_ Phone: \_\_\_\_\_

### 6. Name and phone number of the physician who signed the death certificate.

Last: \_\_\_\_\_ First: \_\_\_\_\_ Phone: \_\_\_\_\_

### 7. What was the infant's level of consciousness upon arrival at the hospital?

Breathing      Not breathing      Responsive      Unresponsive      Dead

### 8. Describe the infant's appearance at hospital arrival. (indicate all that apply)

Appearance	Present?			Describe and specify location (e.g., nose, mouth, left arm, back)
Discolorations	Yes	No	Unknown	
Secretions	Yes	No	Unknown	
Livor mortis	Yes	No	Unknown	
Pale areas around nose or mouth	Yes	No	Unknown	
Retinal hemorrhages	Yes	No	Unknown	
Cutaneous petechiae	Yes	No	Unknown	
Bruising or other injury	Yes	No	Unknown	
Suspicion of inflicted trauma	Yes	No	Unknown	
Malnourished	Yes	No	Unknown	
Other:	Yes	No	Unknown	

### 9. How did the infant feel upon arrival at the hospital? (check all that apply)

Sweaty      Warm to touch      Cool to touch      Limp/flexible      Rigid/stiff      Unknown

Other, specify: \_\_\_\_\_

**10. List all treatments and procedures administered to the infant at the hospital.**

Treatment or procedure	Approximate time	Outcome

**11. What were the hospital staff's comments regarding family's reaction to infant's death?**

**Investigator's Notes**

**1. Indicate the task(s) performed.**      EMS run report/sheet      911 tape

**2. Name of the person who completed this section.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**3. What date and time was this section completed?**

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

**4. How was the interview conducted?**

In person      Telephone      Other, specify: \_\_\_\_\_

## D. Immunization Record

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. Indicate information source(s). (check all that apply)

Biological mother/father      Grandmother/father      Adoptive or foster parents      Physician  
Health records      Other, specify: \_\_\_\_\_

### 3. Had the infant ever received immunizations or shots?      Yes      No      Unknown

If yes, list all the immunizations the infant had ever been given in the table below or attach record.

Immunization	Date (mm/dd/yyyy)	Comments/reactions
Hepatitis B #1		
Hepatitis B #2		
Hepatitis B #3		
Rotavirus #1		
Rotavirus #2		
Rotavirus #3 is RotaTeq given		
Diphtheria, Tetanus, Pertussis #1 (DPT)		
Diphtheria, Tetanus, Pertussis #2 (DPT)		
Diphtheria, Tetanus, Pertussis #3 (DPT)		
Haemophilus Influenzae Type b #1 (Hib)		
Haemophilus Influenzae Type b #2 (Hib)		
Haemophilus Influenzae Type b #3 (Hib)		
Inactivated Poliovirus #1 (Polio)		
Inactivated Poliovirus #2 (Polio)		
Inactivated Poliovirus #3 (Polio)		
Pneumococcal #1		
Pneumococcal #2		
Pneumococcal #3		
Influenza (Flu)		
Other, specify:		

### 4. Are the immunizations up to date?      Yes      No      Unknown

## Investigator's Notes

### 1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

### 2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## E. Infant Exposure History

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. Identify all persons who were in contact with the infant in the 24 hours prior to the infant's death.

(include those who were in the same room and living in/staying in/visiting the infant's primary residence)

Identify	Person 1	Person 2	Person 3
Last name			
First name			
Maiden name (if applicable)			
Relationship to infant			
Address			
Date of birth (mm/dd/yyyy)			
Where did contact with the infant occur (e.g., house, daycare, playground)			
Date of last contact with the infant (mm/dd/yyyy)			
Approximate time of last contact with the infant (military time)			
	Yes No Unknown	Yes No Unknown	Yes No Unknown
During the week prior to the infant's death, was this person sick?	If yes, explain:	If yes, explain:	If yes, explain:
	Yes No Unknown	Yes No Unknown	Yes No Unknown
Has this person experienced the death of any of their own children or any other children while in their care?	If yes, explain:	If yes, explain:	If yes, explain:
	Yes No Unknown	Yes No Unknown	Yes No Unknown
For persons biologically related to the infant, are there any known conditions/diseases than run in the family? (e.g., Down syndrome)	If yes, explain:	If yes, explain:	If yes, explain:
<b>Not a family member</b>			
Child's name			
Relationship to caregiver			
Date of death (mm/dd/yyyy)			
Child's age at death (years, or months if <2 years)			
Cause of death			
Place of death			

### 3. Did the infant visit a location with large numbers of people within the last 24 hours? Yes No

If yes, describe:



**4. Are there any factors, circumstances, or environmental concerns?**

(e.g., mother smoked while breast feeding, exposed to a large number of people at church or public event, air travel)

Yes No

If yes, describe:

**5. Did the infant visit a daycare in the 24 hours prior to the death?** Yes No

If yes: How many adults aged 18 years or older were supervising the children? \_\_\_\_\_

Were any of these adults sick? Yes No

If yes, specify: \_\_\_\_\_

How many children younger than 18 years of age were under the care of the provider on that day? \_\_\_\_\_

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

Identify	Child 1	Child 2	Child 3
First name of child			
Last name of child			
Date of birth (mm/dd/yyyy)			
Where did contact with the infant occur? (e.g., house, daycare, playground)			
Date of last contact with the infant (mm/dd/yyyy)			
Approximate time of last contact with the infant			

If more than 3 children, use blank pages.

**Investigator's Notes**

**1. Name of the person who completed this section.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**2. What date and time was this section completed?**

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## F. Informant Contact

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. For each informant interviewed, please obtain the following information.

Item	Informant 1	Informant 2	Informant 3
Last name			
First name			
Middle name			
Maiden (if applicable)			
Relationship to infant			
Address (home)			
Address (work)			
Phone			
Email			

Item	Informant 4	Informant 5	Informant 6
Last name			
First name			
Middle name			
Maiden (if applicable)			
Relationship to infant			
Address (home)			
Address (work)			
Phone			
Email			

### Investigator's Notes

#### 1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

#### 2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## G. Law Enforcement Interview

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. Information about the law enforcement officer interviewed.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Agency: \_\_\_\_\_

3. What date and time was law enforcement dispatched? Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

### 4. Information about the person who called law enforcement?

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Relationship to infant: (e.g., aunt) \_\_\_\_\_

5. What date and time did law enforcement arrive at the scene? Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

### 6. Describe the infant's appearance when law enforcement arrived at the scene.

Appearance	Present?	Describe and specify location (e.g., nose, mouth, left arm, back)
Discoloration around face, nose, or mouth	Yes No Unknown	
Secretions or fluids (e.g., foam, froth, or urine)	Yes No Unknown	
Skin discoloration (e.g., livor mortis, pale areas, darkness, or color changes)	Yes No Unknown	
Pressure marks (e.g., pale areas, or blanching)	Yes No Unknown	
Rash or petechiae (e.g., small, red blood spots on skin, membrane, or eyes)	Yes No Unknown	
Marks on body (e.g., scratches or bruises)	Yes No Unknown	
Other:	Yes No Unknown	

### 7. How did the infant feel to law enforcement when they arrived at the scene? (check all that apply)

Sweaty Warm to touch Cool to touch Limp/flexible Rigid/stiff Unknown

Other, specify: \_\_\_\_\_

### 8. How would law enforcement describe the surface on which the infant was placed prior to death? (check all that apply)

Soft Firm Lumpy Concave Stained Wet

Other, describe: \_\_\_\_\_

### 9. How would law enforcement describe the condition of the sleep environment? (check all that apply)

Broken Worn Repaired Clean Dirty

Other, describe: \_\_\_\_\_

### 10. Describe what the scene looked like to law enforcement upon arrival.

**11. Describe what law enforcement did at the scene.**

**12. Are there any known prior contacts with law enforcement?**

Individual	Prior contact(s)?		Reason for contact(s)	Outcome
Mother	Yes	No		
Father	Yes	No		
Placer	Yes	No		
Finder	Yes	No		
Person who last saw infant alive	Yes	No		
Other, specify:	Yes	No		

**13. What was the final disposition of the infant?**

Released to funeral home                      Morgue                      ME/C facility

Transported to the hospital, specify: \_\_\_\_\_

Other, specify: *(indicate facility name and name of person who received the infant)*

**14. Have there been any contacts with complaints to social services regarding this family and other siblings in the home?      Yes      No**

*If yes:* What is the total number of contacts with social services? \_\_\_\_\_

**List two of the most recent contacts with social services.**

Contact 1's Information	
Date contacted: <i>(mm/dd/yyyy)</i>	Caseworker name:
Agency name:	
Reason for contact:	
Outcome:	
Comments:	

Contact 2's Information	
Date contacted: <i>(mm/dd/yyyy)</i>	Caseworker name:
Agency name:	
Reason for contact:	
Outcome:	
Comments:	

**Investigator's Notes**

**1. Name of the person who completed this section.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

**2. What date and time was this section completed?**

Date: *(mm/dd/yyyy)* \_\_\_\_\_ Military time: \_\_\_\_\_

## H. Material Collections - Log

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. Describe all items recovered from the site of the incident or death scene.

Item	Evidence number and origin	Description	Disposition	Name of person collecting
Baby bottles	Evidence no: _____ Origin: _____			
Pacifier	Evidence no: _____ Origin: _____			
Formula	Evidence no: _____ Origin: _____			
Bedding	Evidence no: _____ Origin: _____			
Infant's last diaper	Evidence no: _____ Origin: _____			
Clothing	Evidence no: _____ Origin: _____			
Apnea monitor	Evidence no: _____ Origin: _____			
Infant sleep surface	Evidence no: _____ Origin: _____			
Medicines <i>(include home remedies)</i>	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			

Item	Evidence number and origin	Description	Disposition	Name of person collecting
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			
Other, specify:	Evidence no: _____ Origin: _____			

**Investigator's Notes**

1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

# I. Nonprofessional Responder Interview

## 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

## 2. Information about the first non-professional responder to the infant.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Phone number: \_\_\_\_\_

Email: \_\_\_\_\_ Relationship to Infant: \_\_\_\_\_

Sex: Male Female Age: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

## 3. What led this person to respond?

\_\_\_\_\_

## 4. What was the infant's level of consciousness when found? Breathing Not breathing Responsive Unresponsive

If not breathing, did the non-professional responder witness the infant stop breathing? Yes No

## 5. Describe infant's appearance to the responder when found.

Appearance	Present?			Describe and specify location (e.g., nose, mouth, left arm, back)
Discoloration around face, nose, or mouth	Yes	No	Unknown	
Secretions or fluids (e.g., foam, froth, or urine)	Yes	No	Unknown	
Skin discoloration (e.g., livor mortis, pale areas, darkness, or color changes)	Yes	No	Unknown	
Pressure marks (e.g., pale areas, or blanching)	Yes	No	Unknown	
Rash or petechiae (e.g., small, red blood spots on skin, membrane, or eyes)	Yes	No	Unknown	
Marks on body (e.g., scratches or bruises)	Yes	No	Unknown	
Other: _____	Yes	No	Unknown	

## 6. How did the infant feel to the responder when found? (check all that apply)

Sweaty Warm to touch Cool to touch Limp/flexible Rigid/stiff Unknown

Other, specify: \_\_\_\_\_

## 7. What date and time were the first resuscitative efforts given?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## 8. Where were resuscitative efforts conducted?

\_\_\_\_\_

## 9. Describe what this person did as part of the resuscitative efforts. (e.g., pushed on chest, and breathed into mouth and nose)

\_\_\_\_\_

## 10. Had this person ever received any First Aid and/or CPR training? Yes No

If yes: When? \_\_\_\_\_

Describe: \_\_\_\_\_

## Investigator's Notes

### 1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

### 2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## J. Parental Information

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

### 2. Indicate information source:

Biological mother/father

Grandmother/father

Adopted or foster parents

Physician

Health records

Other, specify: \_\_\_\_\_

### 3. Information about the infant's mother:

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Maiden name: (if applicable) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

### 4. Information about the infant's biological mother: Same as above

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Maiden name: (if applicable) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

### 5. Information about the infant's father:

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

### 6. Information about the infant's biological father: Same as above

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_



**7. Information about the infant's other primary caregivers.** (e.g., babysitter while parents are at work)

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Maiden name: (if applicable) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

**8. Information about the infant's other primary caregivers.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Maiden name: (if applicable) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

**9. Information about the infant's other primary caregivers.**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Maiden name: (if applicable) \_\_\_\_\_

Current address. Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

List all previous states: \_\_\_\_\_

**Investigator's Notes**

1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

## K. Primary Residence Investigation

### 1. Infant's name.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_ Case number: \_\_\_\_\_

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

### 2. Address of infant's primary residence.

Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 3. How many people live at the infant's primary residence?

Number of adults: (18 years or older) \_\_\_\_\_ Number of children: (under 18 years of age) \_\_\_\_\_

### 4. What type of building is the primary residence?

Apartment

Institution (e.g., shelter)

Mobile home

Multi-family home

Single-family house

Other, specify: \_\_\_\_\_

### 5. Which of the following heating or cooling sources were being used? (check all that apply)

Central air

Electric furnace or boiler

Kerosene space heater

A/C window unit

Electric space heater

Window fan

Ceiling fan

Electric (radiant) ceiling heat

Other, specify:

Electric baseboard heat

Woodburning fireplace

Gas furnace or boiler

Coal burning furnace

### 6. The infant's primary residence has: (check all that apply)

Insects

Mold growth

Presence of alcohol

Pets

Dampness

Presence of drugs

Peeling paint

Visible standing water

Odors or fumes, describe:

Rodents or vermin

Smoky smell (e.g., cigarettes)

Other, specify: \_\_\_\_\_

### 7. What is the source of drinking water at the infant's primary residence? (check all that apply)

Public/municipal water source

Bottled water

Other, specify:

Well

Unknown

### 8. What is the general appearance of the infant's primary residence? (e.g., cleanliness, hazards, overcrowding, etc.)

## Investigator's Notes

### 1. Name of the person who completed this section.

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.: \_\_\_\_\_

### 2. What date and time was this section completed?

Date: (mm/dd/yyyy) \_\_\_\_\_ Military time: \_\_\_\_\_

**Scene diagram** (*illustrate the infant's sleep environment*)

A large grid of graph paper, consisting of 30 columns and 40 rows of small squares, intended for drawing a scene diagram of an infant's sleep environment.