Per ARS §36-3506, completion of this form is required for any death investigation of children younger than 12 months of age.

Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

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

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? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ Unknown		

FATHER OR CAREGIVER #2

Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):		Smoker? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ 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? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ 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:

One	Two	
☐	☐	Biological parent
☐	☐	Adoptive parent
☐	☐	Step parent
☐	☐	Foster parent
☐	☐	Mother's partner
☐	☐	Father's partner
☐	☐	Grandparent
☐	☐	Sibling
☐	☐	Other relative
☐	☐	Friend/Neighbor
☐	☐	Unknown
☐	☐	Daycare Provider
		☐ Licensed
		☐ Unlicensed
☐	☐	Other Specify:

2. Caregiver(s) age in years

One	Two	
___	___	# years
☐	☐	Unknown

3. Caregiver(s) Sex:

One	Two	
☐	☐	Male
☐	☐	Female
☐	☐	Unknown

4. Caregiver(s) employment status:

One	Two	
☐	☐	Employed
☐	☐	Unemployed
☐	☐	On disability
☐	☐	Stay-at-home
☐	☐	Retired
☐	☐	Unknown

5. Caregiver(s) substance use history

One	Two	
☐	☐	No
☐	☐	Yes
☐	☐	Unknown

If yes, check all that apply

☐	☐	Alcohol
☐	☐	Cocaine
☐	☐	Marijuana
☐	☐	Methamphetamine
☐	☐	Opiates
☐	☐	Prescriptions
☐	☐	Over the counter
☐	☐	Unknown
☐	☐	Other, Specify:

6. Caregiver(s) have prior child death:

One	Two	
☐	☐	No
☐	☐	Yes
☐	☐	Unknown

If yes, cause(s) Check all that apply

☐	☐	Abuse #___
☐	☐	Neglect #___
☐	☐	Accident #___
☐	☐	Suicide #___
☐	☐	SIDS #___
☐	☐	Unknown #___
☐	☐	Other #___

MEDICAL EXAMINERS OFFICE FAX NUMBERS

Apache	**(866) 593-6192**
Cochise	**(520) 724-8610**
Coconino	**(928) 779-7056**
Gila	**(928) 474-1658**
Graham	**(928) 348-4033**
Greenlee	**(520) 724-8610**
La Paz	**(520) 724-8610**
Maricopa	**(602) 506-1546**
Mohave	**(928) 505-5889**
Navajo	**(928) 532-6054**
Pima	**(520) 724-8610**
Pinal	**(520) 866-7296**
Santa Cruz	**(520) 724-8610**
Yavapai	**(928) 771-3504**
Yuma	**(928) 336-1608**

Per ARS §36-3506, completion of this form is required for any death investigation of children younger than 12 months of age.

Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

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

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

What led someone to check on the infant? _____

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

Describe child's appearance when found:	**No**	**Yes**	**Unknown**	**Describe/specify location:**	**First Assessed by:**
Discoloration around face/nose/mouth	☐	☐	☐		☐ EMS
Secretions (foam, froth)	☐	☐	☐		☐ ER
Skin discoloration (livor mortis)	☐	☐	☐		☐ PD
Pressure marks (pale areas, blanching)	☐	☐	☐		
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)	☐	☐	☐		
Marks on body (scratches or bruises)	☐	☐	☐		
Infant moved prior to being found	☐	☐	☐		

Time frame information:

Time Found _____ **Last Seen Alive** _____ **Time Police Called** _____ **Call Type:** ☐ **911** ☐ **Regular** ☐ **Other, specify:** _____

Last Feeding Time _____

Person Calling _____

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

☐ **Sweaty** ☐ **Warm to touch** ☐ **Cool to touch** **Surface body temperature:**

☐ **Limp, flexible** ☐ **Rigid, stiff** ☐ **Unknown** **Temperature at hospital:**

☐ **Other, Specify:**

SUFFOCATION/ASPHYXIA

A. Type of Event

☐ Suffocation, go to **B**.

☐ Strangulation, go to **C**.

☐ Choking, go to **D**.

B. If suffocation/asphyxia, action causing event:

☐ Sleep-related (e.g. bedding, overlay, wedged) ☐ Confined in tight space ☐ Swaddled in tight blanket, not sleep related

☐ Covered in or fell into object, not sleep related ☐ Refrigerator/freezer ☐ Wedged into tight space, but not sleep related

☐ Plastic bag ☐ Toy chest ☐ Asphyxia by gas

☐ Dirt/Sand ☐ Automobile ☐ Unknown

☐ Unknown ☐ Trunk ☐ Other, Specify:

☐ Other, Specify: ☐ Unknown

☐ Other, Specify:

C. If strangulation, object causing event:

☐ Clothing ☐ High chair ☐ Electrical cord

☐ Blind cord ☐ Belt ☐ Automobile power window or sunroof

☐ Car seat ☐ Rope/string ☐ Unknown ☐ Person

☐ Stroller ☐ Leash ☐ Other, Specify:

D. If choking, object causing choking:

☐ Food, Specify:

☐ Toy, Specify:

☐ Balloon ☐ Unknown

☐ Other, Specify:

OTHER CIRCUMSTANCES OF INCIDENT – ANSWER RELEVANT SECTIONS

DID DEATH OCCUR WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT? ☐ No ☐ Yes

A. **INCIDENT** sleep place:	If adult bed, What type?	C. Child put to sleep:	D. Child found:
☐ Crib ☐ Playpen ☐ Car seat/Stroller ☐ Bassinette ☐ Couch ☐ Unknown ☐ Adult bed ☐ Chair ☐ Other, Specify: ☐ Waterbed ☐ Floor	☐ Twin ☐ King ☐ Full ☐ Unknown ☐ Queen ☐ Other, Specify:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown By Whom:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown By Whom:

E. Was there a crib, bassinette, or port-a-crib in home for child? ☐ No ☐ Yes ☐ Unknown

F. **USUAL** sleep place:	If adult bed, what type?	G. **USUAL** sleep position:	H. Child in new or different environment?
☐ Crib ☐ Playpen ☐ Car seat/Stroller ☐ Bassinette ☐ Couch ☐ Unknown ☐ Adult bed ☐ Chair ☐ Other, Specify: ☐ Waterbed ☐ Floor	☐ Twin ☐ King ☐ Full ☐ Unknown ☐ Queen ☐ Other, Specify:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown	☐ No ☐ Yes ☐ Unknown

Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

CIRCUMSTANCES when child found:

Child's airway was:

- ☐ Unobstructed by person or object
- ☐ Fully obstructed by person or object
- ☐ Partially obstructed by person or object
- ☐ Unknown

Child's position most relevant to death:

- ☐ On top of
- ☐ Under
- ☐ Between
- ☐ Wedged into
- ☐ Pressed into
- ☐ Fell or rolled onto
- ☐ Tangled in
- ☐ Unknown
- ☐ Other, Specify:

With what objects or persons? Check all that apply:

- ☐ Adult
- ☐ Child(ren)
- ☐ Animal(s)
- ☐ Blanket
- ☐ Pillow
- ☐ Comforter
- ☐ Mattress
- ☐ Bumper pads
- ☐ Waterbed mattress
- ☐ Air mattress
- ☐ Pillow-top mattress
- ☐ Crib rail
- ☐ Couch
- ☐ Car seat/stroller
- ☐ Stuffed toy
- ☐ Chair, Type:
- ☐ Clothing
- ☐ Cord
- ☐ Plastic bag
- ☐ Wall
- ☐ Unknown
- ☐ Other, Specify:

Child sleeping on same surface with person(s) or animal(s)? Check all that apply:

- ☐ With adults: Number:_____ Adult obese: ☐ No ☐ Yes ☐ Unknown Alcohol/Drugs? ☐ No ☐ Yes
- ☐ With other child(ren): Number:_____ Child(ren)'s ages:
- ☐ With animal(s): Number:_____ Type(s) of animals:
- ☐ Unknown ☐ Number Unknown

What food/liquids was the child fed in the last 24 hours?	**No**	**Yes**	**Unknown**	**Quantity (Specify type & brand, if applicable)**
Breast milk (one/both sides, length of time)	☐	☐	☐	ounces
Formula (brand, water source – ex. Similac, tap water)	☐	☐	☐	ounces
Was the formula mixed according to directions?	☐	☐	☐	
Cow's milk	☐	☐	☐	ounces
Water (brand, bottled, tap, well)	☐	☐	☐	ounces
Other liquids (juices, teas)	☐	☐	☐	ounces
Solids, specify:	☐	☐	☐	ounces
Other, specify:	☐	☐	☐	ounces

Was a new food introduced in the 24 hours prior the child's death?

☐ No ☐ Yes ☐ Unknown If yes, describe:

Was the child last placed to sleep with a bottle?

☐ No ☐ Yes ☐ Unknown **How was formula prepared:**

Was the bottle propped on object while feeding?

☐ No ☐ Yes ☐ Unknown If yes, what object used?

What was the quantity of liquid (in ounces) in the bottle?

Did the death occur during:	☐ Breastfeeding	☐ Bottle feeding	☐ Eating solid foods	☐ Not during feeding

RECENT MEDICAL HISTORY

Source of medical information:

☐ Mother/primary care giver ☐ Family ☐ Doctor ☐ Medical records ☐ Other healthcare provider ☐ Other, Specify:

In the 72 hours prior to death, did the child have: (check all that apply)

	No	**Yes**	**Unknown**		**No**	**Yes**	**Unknown**
Fever	☐	☐	☐	Diarrhea	☐	☐	☐
Excessive sweating	☐	☐	☐	Difficulty breathing	☐	☐	☐
Weakness or sleeping more than usual	☐	☐	☐	Cough/wheezing	☐	☐	☐
Fussiness or excessive crying	☐	☐	☐	Apnea (stopping breathing)	☐	☐	☐
Decrease in appetite	☐	☐	☐	Cyanosis (turned blue/gray)	☐	☐	☐
Vomiting	☐	☐	☐	Seizures or convulsions	☐	☐	☐
Choking	☐	☐	☐	Other, Specify:			

In the 72 hours prior to death, was the child injured or did child have any other condition(s) not mentioned?

☐ No ☐ Yes If yes, describe:

In the 72 hours prior to the death, did the child receive any vaccinations, medications, or exposure to any chemicals?
(Please include any home remedies, herbal medications, prescription medicines or over-the-counter medications including "cough, cold medicine")

☐ No ☐ Yes If yes, describe/list:

Any recent visit to a medical provider?

☐ No ☐ Yes If yes, When? Doctor/Facility: Why?

Per ARS §36-3506, completion of this form is required for any death investigation of children younger than 12 months of age.

Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

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

HEALTH INFORMATION

Child's Primary Care Physician: **Phone: ( )** **Last Visit: When?** **Why:**

Allergies: **Birth defects:**

Medications:

Has the child been immunized? ☐ No ☐ Yes ☐ Unknown **Date of last immunization:**

Immunizations current? ☐ No ☐ Yes ☐ Unknown **If immunized within the last 30 days, specify type:**

Does the child use any home monitors? ☐ No ☐ Yes **Type/Brand:**

If Yes, was child on home monitor at time of death? ☐ No ☐ Yes

Anyone else in household or other contacts (e.g. daycare) recently ill? ☐ No ☐ Yes

Family history of genetic/inheritable disease(s)? ☐ No ☐ Yes, Specify:

BIRTH INFORMATION

Birth place (home, hospital name and location):

Birth complications? ☐ No ☐ Yes **If yes, specify:**

Gestational Age	Birth Weight:	Multiple Birth?	# of prenatal visits	Month of first prenatal visit
☐ Unknown ____ weeks	☐ Unknown ____ grams pounds/ounces	☐ No ☐ Yes, #____	☐ Unknown # ____	Specify 1-9: ____ ☐ Unknown ☐ None

During pregnancy, did mother (check all that apply):

☐ Smoke tobacco ☐ Experience intimate partner violence ☐ Heavy alcohol use ☐ Misuse OTC or prescription drugs
☐ Use illicit drugs ☐ Child born drug exposed ☐ Child born with fetal alcohol effects or syndrome

☐ During pregnancy, did mother have medical complications/infections? (check all that apply) Specify type, if known

	Type		Type
☐ Lung Disease	____	☐ Preterm Labor	____
☐ Heart Disease	____	☐ Premature Rupture Membrane	____
☐ Blood Disorder	____	☐ Vaginal Bleeding	____
☐ Infectious Disease	____	☐ Diabetes Mellitus	____
☐ Familial Genetic Disorder		☐ Other	____

Were there access or compliance issues related to prenatal care?

☐ No
☐ Yes
If yes, check all that apply:
☐ Unknown

☐ Lack of money for care
☐ Limited or no health insurance coverage
☐ Lack of transportation
☐ Lack of child care
☐ No phone

☐ Religious objections to care
☐ Cultural differences
☐ Unwilling to obtain care
☐ Did not know care needed
☐ Other, specify:

SCENE DOCUMENTATION

Photos of Death Scene Taken? ☐ No ☐ Yes

Property Seized? ☐ No ☐ Yes **What Agency Seized Property?**

Formula? ☐ No ☐ Yes **Bottles/Contents?** ☐ No ☐ Yes **Bedding?** ☐ No ☐ Yes **Crib?** ☐ No ☐ Yes

Other, Specify:

Was there an open CPS case with child at time of death? ☐ No ☐ Yes ☐ Unk

Was the child ever placed outside of the home prior to death? ☐ No ☐ Yes **Date of Placement:**

Were any siblings placed outside of the home prior to this child's death? ☐ No ☐ Yes **Date of Placement:**

PERSON COMPLETING FORM

Name (please print or type):

Agency:

Telephone: ( ) **Fax: ( )** **Date:**

Signature: **Date Signed:**

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