NEBRASKA

Sudden Unexpected Infant Death Investigation

Reporting Form

NEBRASKA
DEPT. OF HEALTH AND HUMAN SERVICES

Date *(mm/dd/yyyy)*: _____ Time of call: _____ Case number: _____

INFANT DEMOGRAPHICS

Infant name: _____ Age: _____ ○ Days ○ Months

Primary residence address: _____

City: _____ State: NEBRASKA Zip: _____

Date of birth *(mm/dd/yyyy)*: _____ Date of death *(mm/dd/yyyy)*: _____ Time of death: _____

Race: □ White □ Black/African Am. □ Asian/Pacific Islander □ Am. Indian/Alaskan Native □ Hispanic/Latino □ Other

Sex: ○ Male ○ Female

PARENT INFORMATION

Parent 1 name: _____ Date of birth *(mm/dd/yyyy)*: _____ Age: _____

Primary phone: _____ Secondary phone: _____

Address: ○ Same as infant ○ _____

Parent 2 name: _____ Date of birth *(mm/dd/yyyy)*: _____ Age: _____

Primary phone: _____ Secondary phone: _____

Address: ○ Same as infant ○ _____

PREGNANCY HISTORY

Infant's weight at birth *(lbs and oz/grams)*: _____ Infant's length at birth *(inches/cm)*: _____

Compared to the due date, when was the infant born?

Early *(before 37 weeks)* ○ On time ○ Late *(after 41 weeks)*

How many weeks? _____ Infant's due date *(mm/dd/yyyy)*: _____

Was the infant a singleton or multiple birth? ○ Singleton ○ Twin ○ Triplet or higher

Were there any complications during delivery or at birth? ○ Yes ○ No ○ Unk.

If yes, describe: _____

Hospital or place of birth: _____ Attending physician: _____

Did the mother receive prenatal care? ○ Yes ○ No ○ Unk.

Prenatal care provider: _____

During her pregnancy, did the mother use any of the following:

Substance	Use	Specify Type	Frequency
Over the counter medications	○ Yes ○ No ○ Unk.		
Prescribed medications	○ Yes ○ No ○ Unk.		
Herbal remedies	○ Yes ○ No ○ Unk.		
Alcohol	○ Yes ○ No ○ Unk.		
Recreational drugs	○ Yes ○ No ○ Unk.		
Tobacco	○ Yes ○ No ○ Unk.		

INFANT HISTORY

Pediatrician: _____ Office phone: _____

Within 72 hours of death, did the infant receive any of the following:

Substance	Use	Specify Type	Frequency
Over the counter medications	○ Yes ○ No ○ Unk.		
Prescribed medications	○ Yes ○ No ○ Unk.		
Herbal remedies	○ Yes ○ No ○ Unk.		
Vaccines	○ Yes ○ No ○ Unk.		

Medical problems since birth (list): _____

Birth defects (list): _____

Past hospitalizations: _____

Did the infant have any of the following within 72 hours of the incident:

Symptom	Within 72 hrs of incident
Allergies or allergic reactions (food, medication, or other)	○ Yes ○ No ○ Unk.
Apnea (stopped breathing)	○ Yes ○ No ○ Unk.
Cardiac (heart) problems	○ Yes ○ No ○ Unk.
Choking	○ Yes ○ No ○ Unk.

Cough	○ Yes ○ No ○ Unk.
Cyanosis (turned blue or gray)	○ Yes ○ No ○ Unk.
Decrease in appetite	○ Yes ○ No ○ Unk.
Diarrhea	○ Yes ○ No ○ Unk.
Difficulty breathing	○ Yes ○ No ○ Unk.
Excessive sweating	○ Yes ○ No ○ Unk.
Exposure to anyone who was sick	○ Yes ○ No ○ Unk.
Falls, injuries, accidents	○ Yes ○ No ○ Unk.
Feeding issues *(e.g., reflux)*	○ Yes ○ No ○ Unk.
Fever	○ Yes ○ No ○ Unk.
Fussiness or excessive crying	○ Yes ○ No ○ Unk.
Lethargy or sleeping more than usual	○ Yes ○ No ○ Unk.
Seizures or convulsions	○ Yes ○ No ○ Unk.
Stool changes	○ Yes ○ No ○ Unk.
Vomiting	○ Yes ○ No ○ Unk.
Other, specify: _____	○ Yes ○ No ○ Unk.

Did infant <u>ever</u> have any of the following:

Symptom	
Abnormal growth, weight gain, or weight loss	○ Yes ○ No ○ Unk.
Allergies or allergic reactions (food, medication, or other)	○ Yes ○ No ○ Unk.
Apnea (stopped breathing)	○ Yes ○ No ○ Unk.
Cardiac (heart) problems	○ Yes ○ No ○ Unk.
Choking	○ Yes ○ No ○ Unk.
Cyanosis (turned blue or gray)	○ Yes ○ No ○ Unk.
Feeding issues *(e.g., reflux)*	○ Yes ○ No ○ Unk.
Fever	○ Yes ○ No ○ Unk.
Seizures or convulsions	○ Yes ○ No ○ Unk.
Vomiting	○ Yes ○ No ○ Unk.
Other, specify: _____	○ Yes ○ No ○ Unk.

Was the infant able to roll over on own?

Front to back	○ Yes ○ No ○ Unk.
Back to front	○ Yes ○ No ○ Unk.

Infant feeding: □ Bottle □ Breast □ Other Time: _____ Amount: _____

Any recent changes in infant's eating habits:

Is the infant exposed to second-hand smoke? ○ Yes ○ No ○ Unk.

Previous history of unexplained death in children or young adults in family: _____

SCENE

Address: ○ Same as infant ○ _____

Caregiver(s) at the time of the incident (name and relationship): _____

Describe what happened:

Was infant in a new or different environment? ○ Yes ○ No

Last time infant was seen alive: _____ By: _____

Time infant was found unresponsive: _____ By: _____

Reporting party (if different than caregiver):

Usual infant sleep position: _____

Swaddled? ○ Yes ○ No

If yes, arm position: ○ Out ○ In ○ One in and one out

Position of infant when put to sleep: _____

Position of infant when found: _____

Face position: ○ Down ○ Up ○ Right ○ Left ○ Other

Neck position: ○ Head back ○ Chin to chest ○ Turned ○ Neutral

Nose, mouth, neck or chest partly or fully obstructed? ○ Yes ○ No

Evidence of wedging: ○ Yes ○ No

Evidence of Overlay: ○ Yes ○ No

Room temperature: ○ Hot ○ Cold ○ Normal ○ Other

Type of sleeping surface:

Sleeping Surface	
Adult bed	○ Yes ○ No ○ Unk.
Baby box	○ Yes ○ No ○ Unk.
Bassinet	○ Yes ○ No ○ Unk.
Bedside sleeper	○ Yes ○ No ○ Unk.
Bouncy chair	○ Yes ○ No ○ Unk.
Car seat	○ Yes ○ No ○ Unk.
Chair	○ Yes ○ No ○ Unk.
Crib	○ Yes ○ No ○ Unk.
Floor	○ Yes ○ No ○ Unk.
Futon	○ Yes ○ No ○ Unk.
Held in person's arms	○ Yes ○ No ○ Unk.

In-bed sleeper	○ Yes ○ No ○ Unk.
Playpen/play area (not portable crib)	○ Yes ○ No ○ Unk.
Portable crib	○ Yes ○ No ○ Unk.
Portable sleeper	○ Yes ○ No ○ Unk.
Sofa/couch	○ Yes ○ No ○ Unk.
Stroller	○ Yes ○ No ○ Unk.
Swing	○ Yes ○ No ○ Unk.
Waterbed	○ Yes ○ No ○ Unk.
Unknown	○ Yes ○ No ○ Unk.
Other, specify:	○ Yes ○ No ○ Unk.

Objects or items present in sleep environment:

Item	Present?	If yes, position in relation to infant?	If yes, did object obstruct the infant's mouth, nose,chest, or neck?
Adult(s) *(18 years or older)*	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Other child(ren) *(younger than 18 years)*	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Animal(s)	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Mattress	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Comforter, quilt or other	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk..	○ Yes ○ No ○ Unk.
Fitted sheet	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Thin blanket	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Pillow(s)	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Cushion	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Nursing or u-shaped pillow	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Sleep positioner *(wedge)*	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Bumper pads	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Clothing *(not on a person)*	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Crib railing or side	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Pacifier	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Wall	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Toy(s)	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.
Other, specify: _____	○ Yes ○ No ○ Unk.	○ Over ○ Under ○ Next to ○ Unk.	○ Yes ○ No ○ Unk.

Which of the following were present at the incident scene:

Symptom	
Dampness	○ Yes ○ No ○ Unk.
Insects	○ Yes ○ No ○ Unk.
Mold growth	○ Yes ○ No ○ Unk.
Odors or fumes, describe: _____	○ Yes ○ No ○ Unk.
Peeling Paint	○ Yes ○ No ○ Unk.

Pets	○ Yes ○ No ○ Unk.
Presence of alcohol containers	○ Yes ○ No ○ Unk.
Presence of illicit drugs or drug paraphernalia, drescribe: _____	○ Yes ○ No ○ Unk.
Presence of prescription drugs, describe:	○ Yes ○ No ○ Unk.
Rodents or vermin	○ Yes ○ No ○ Unk.
Smokey smell	○ Yes ○ No ○ Unk.
Visible standing water	○ Yes ○ No ○ Unk.
None	○ Yes ○ No ○ Unk.
Other, describe: _____	○ Yes ○ No ○ Unk.

Describe the general appearance of incident scene (e.g., cleanliness, hazards, or overcrowding):

Rigor mortis present: ○ Yes ○ No Livor mortis present: ○ Yes ○ No

Foreign substances in infant's mouth or nose: ○ Yes ○ No

If yes, explain: _____

Was infant sharing a sleep surface with: □ Adults □ Other Children □ Pets

What was the infant wearing? _____

Clothing fit: ○ Yes ○ No Clothing clean: ○ Yes ○ No

Attempt to resuscitate? ○ Yes ○ No

If yes, by whom: _____

Resuscitation efforts by EMS: _____

Resuscitation efforts at hospital: _____

Hospital: _____ Attending physician: _____

Arrival time: _____ Who transported: _____

Is body free of bruises, scrapes, cuts, burn marks, diaper rash: ○ Yes ○ No

If no, explain and describe each in detail, noting color, shape, size, and location:

Scene photos taken: ○ Yes ○ No

Evidence collected: ○ Yes ○ No

Scene diagram: ○ Yes ○ No

Signed medical release form obtained: ○ Yes ○ No

NDHHS Protection and Safety notified: ○ Yes ○ No

History obtained: ○ Yes ○ No