

Arizona Infant Death Investigation Checklist

Scene Investigated by _____ Agency _____ Phone Number _____
County _____

A. General Information

1. Infant's name _____; Sex _____; Age _____;
Date of birth _____
2. Date of death _____; Time of death _____ AM/PM; Location _____
3. Father's name _____; Age _____; Occupation _____
4. Mother's name _____; Age _____; Occupation _____
5. Are there siblings? Yes, No; If yes, list ages _____
6. Home address (if different from location of death) _____
7. Pediatrician (family physician) _____ Physician's
Phone _____

B. Past History

8. Birth weight _____ lbs _____ oz; Was infant premature? Yes, No; If yes, number of weeks premature: _____
9. Place of Birth (Hospital and City/State) _____
10. Any problems with pregnancy and delivery? Yes, No; If yes, explain: _____
11. During pregnancy, did anyone: Smoke? Who? _____; Use drugs? Who? _____
What? _____
12. Has infant ever required hospitalization or emergency care? Yes, No; If yes, explain: When? _____
Where? _____,
Why? _____
13. Anything unusual about sleeping habits or breathing? Yes, No; Has infant turned blue or stopped breathing? Yes, No;
Has infant had seizures or convulsions? Yes, No; If yes, explain: _____
14. Any other medical problems or concerns? Yes, No; If yes, explain: _____
15. Has infant been immunized? Yes, No; If yes, are immunizations up to date? Yes, No, Unk;
Date of last immunization: _____
16. Have there been other child deaths in this family or relatives of the immediate family? Yes, No;
If yes, where? _____
Cause of death(s) _____;
Age(s) at death: _____

C. History

17. Was infant: Breast-fed Bottle-fed Both; Last feeding _____AM/PM; What was last feeding? _____
18. Recent illness? Yes, No; If yes, what? Appetite change, Cough, Diarrhea, Ear infection, Fever, Irritability/listlessness, Sniffles, Vomiting, Weakness/ "floppiness", Wheezing, Other _____
- Were medications or home remedies given? Yes, No; If yes, what? _____ *;
Amount _____; Time _____ AM/PM
19. Was there recent exposure to chemicals? Yes, No; If yes, what? _____; When _____
20. Is anybody in the house sick? Yes, No; If yes, who? _____; Illness _____
21. Was there a history of a recent fall or injury? Yes, No; If yes, explain: _____
22. Was the infant in anyone else's care in the last 48 hours? Yes, No; If so, whom? _____
23. Last date infant was seen by a medical provider: _____; Where? _____; Reason for visit: _____

D. Scene

24. Last seen alive _____ AM/PM; Was infant behaving normally? Yes, No; If no, describe: _____
25. Who discovered the infant? Name _____; Relationship _____; Time _____ AM/PM
26. Position infant was in when found? Abdomen, Back, Side; Position when put to bed? Abdomen, Back, Side; What was the infant wearing? _____; How was the infant covered? _____
27. Were the nose and mouth obstructed? Yes, No; If yes, with or by what? _____
28. Describe infant's sleeping environment: Crib, Bed, Sofa, Other _____; Type of mattress: Soft, Hard, Waterbed, Exposed plastic covering. Were any of the following found in infant's bed? Pillow, Blankets, Cushions, Toys, Pets, Other _____; Temperature of room: _____
29. Was the infant sleeping alone? Yes, No; If no, with whom? Child, Adult, More than one person; Estimated weight of sleeper(s): _____; Drug or alcohol used? Yes, No; If yes, what? _____
30. Was the infant: Warm, Cool
31. Were attempts made to revive the infant? Yes, No; If yes, by whom? _____; Time of attempt _____ AM/PM; Method of attempt: CPR, Shaken, Other _____
32. Does anyone in the immediate household or daycare facility smoke? Yes, No; If yes, identify relationship: _____

Comments: (Use this space to elaborate on questions above or to note anything unusual)

*Use “Comments” section if more space is needed. Collect all medication/home remedy containers for submission to Medical Examiner.