

CASE NO. _____ NAME _____

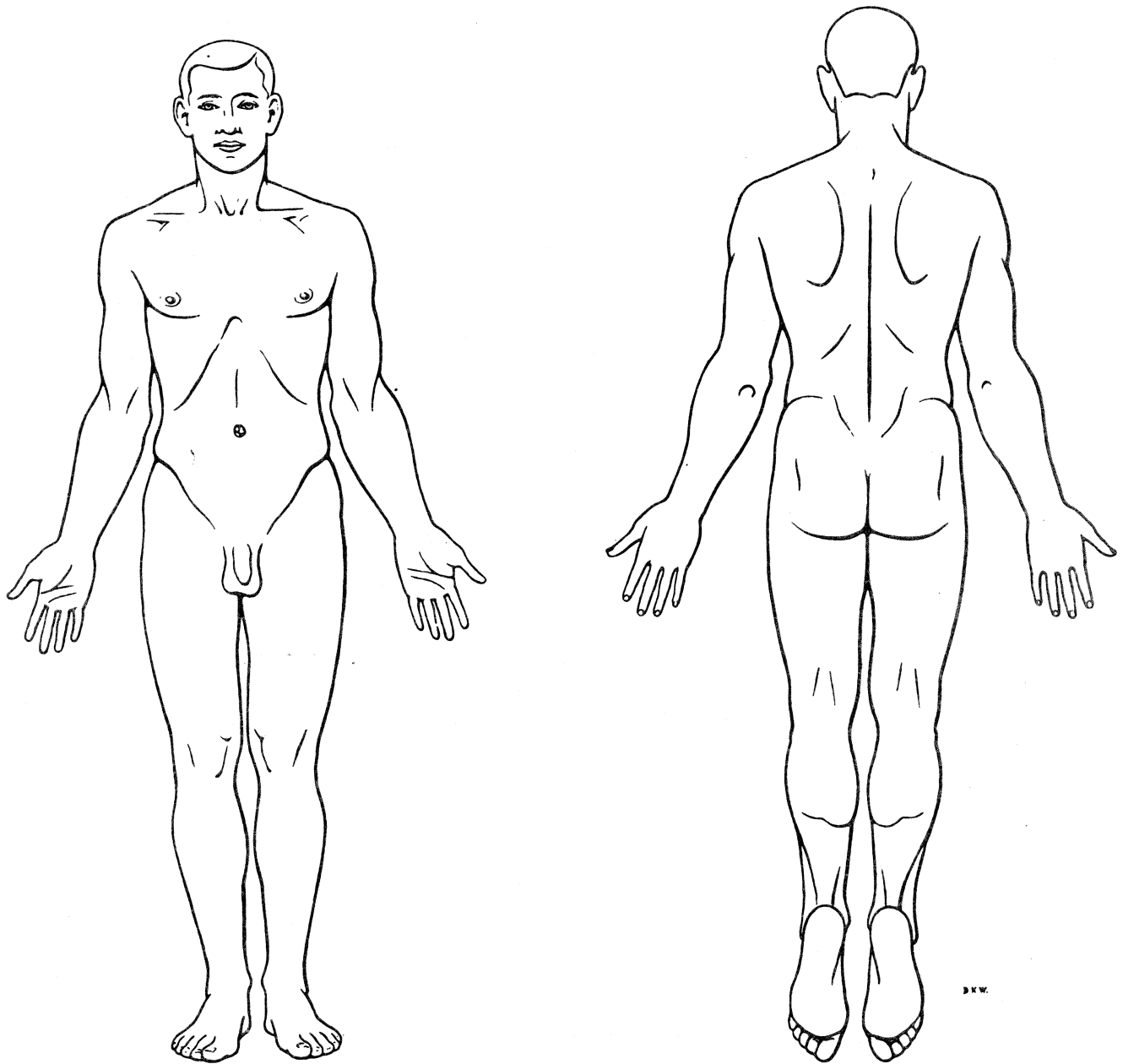
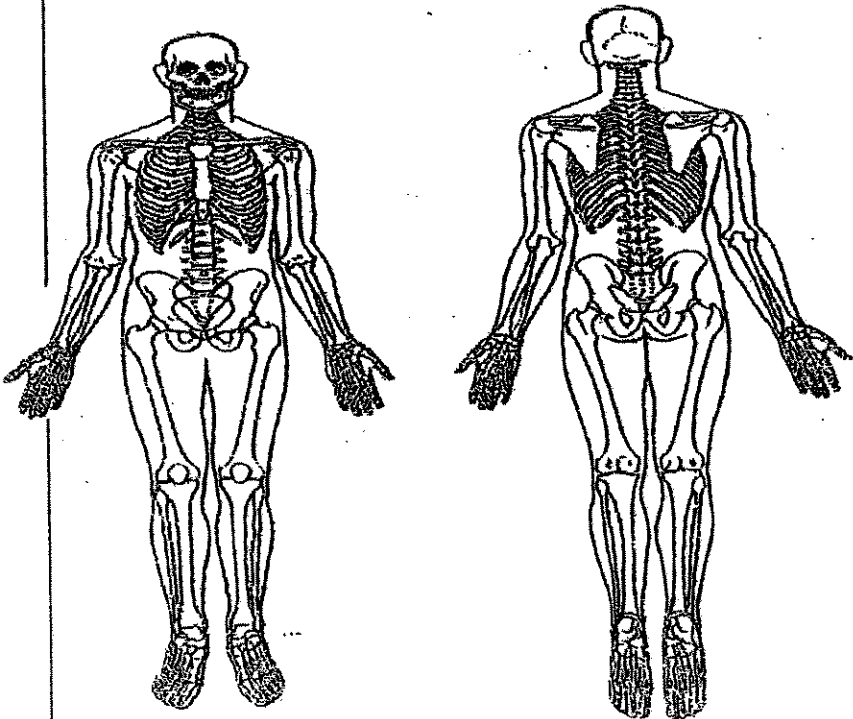


DIAGRAM A

Figure 25 (17)

Autopsy/Specimen Description Sheet

Date:		Place barcode sticker here:
ME Number:		
Name:		
Body Intact?	Y / N	DNA? Yes No
Presumptive ID?	Y / N	Tox? Yes No
Confirmed Finger/Foot?	Y / N	Weight:
Confirmed Dental?	Y / N	Dimensions:
Manner:		Interval:
COD:		
Description:		
Mark out missing body parts or circle applicable fragment.		
		Comments:

Pathologist_____



DIAGRAM B

Figure 25 (18)

CASE NO. _____ NAME _____

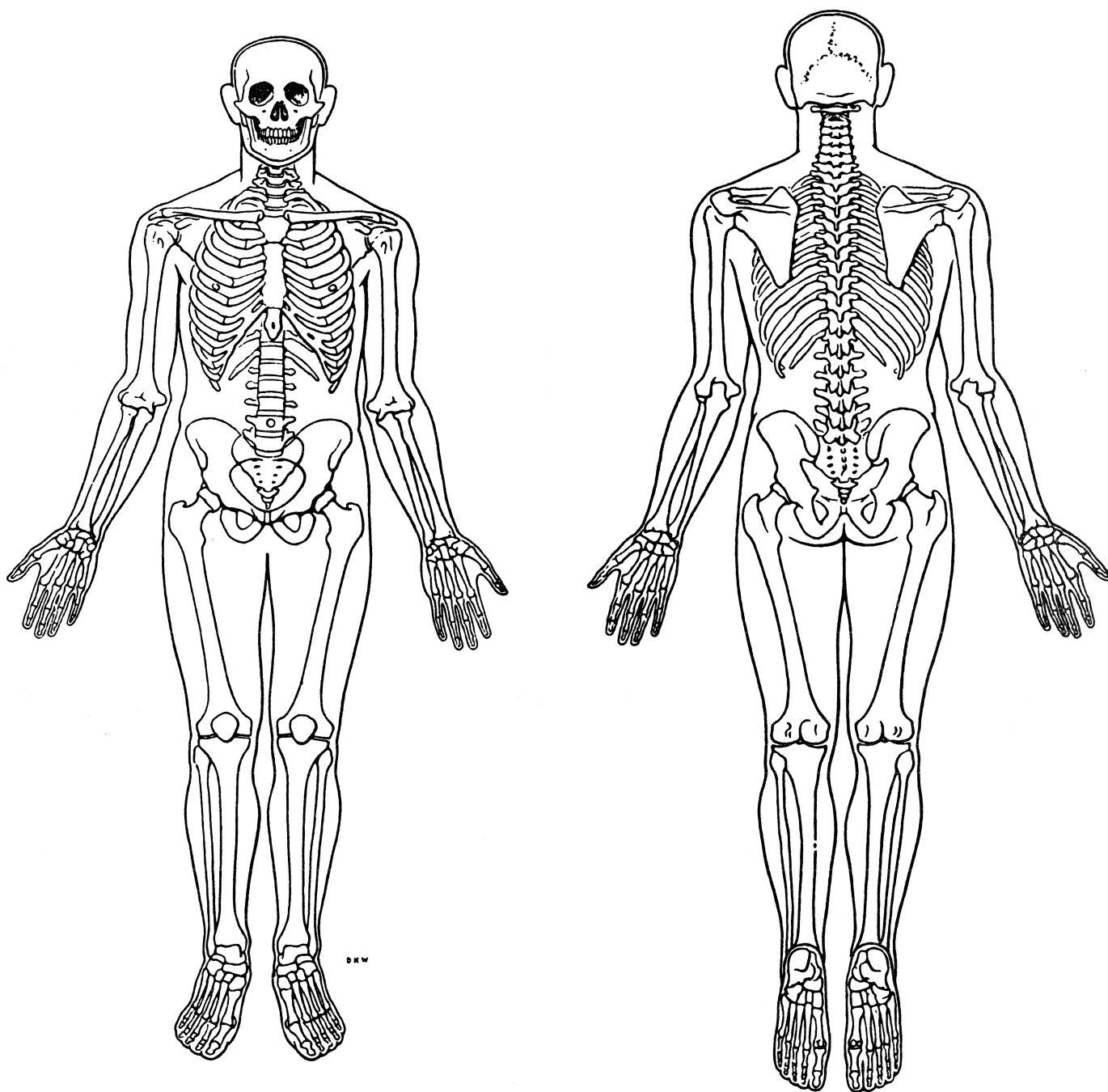


DIAGRAM C

Figure 25 (19)

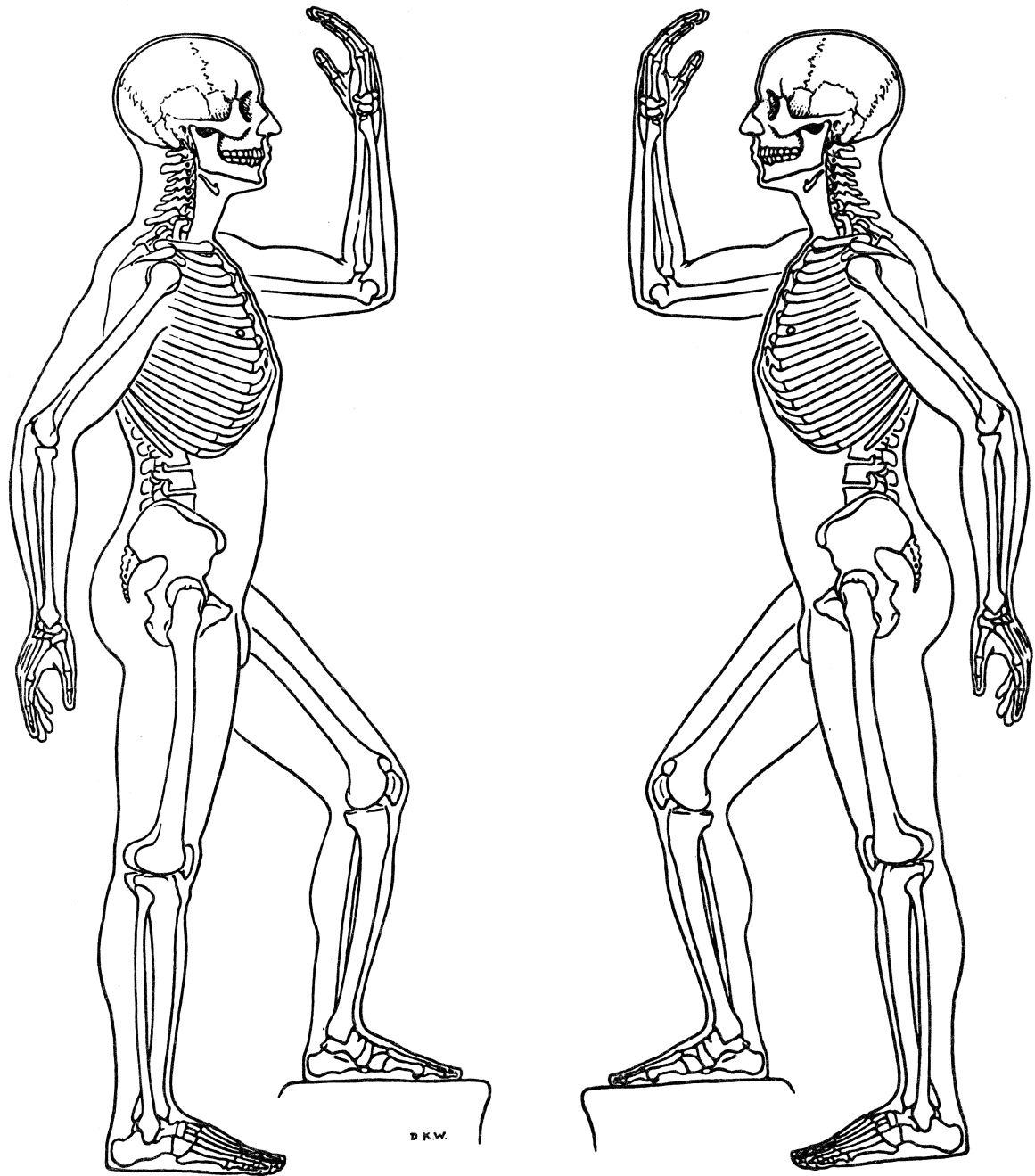


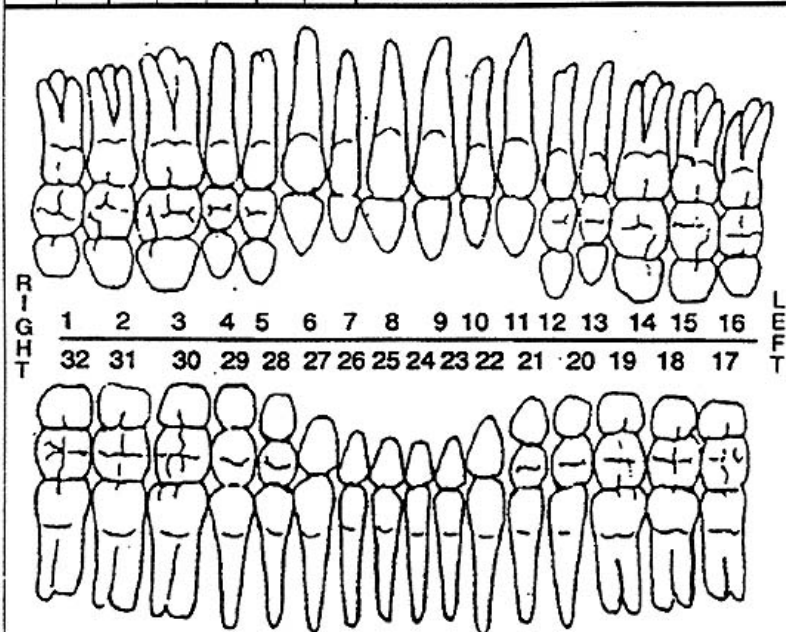
DIAGRAM D

Figure 25 (20)

ANTEMORTEM DENTAL RECORD

SSN	LAST NAME	FIRST NAME	MI	SEX
				M F

DATE OF BIRTH / ESTIMATED AGE	RACE (Circle one)	COMPUTER/DESCRIPTION CODES
	C - Caucasoid N - Negroid	1.
DATE OF RECONSTRUCTION	M - Mongoloid U - Undetermined	2.
	I.D. NUMBER	3.



CAPMI SYMBOLS	
PRIMARY CODES	SECONDARY CODES
C CROWN	A ANOMALY, ROOT TIP, ANY PATHOLOGY
D DISTAL	B PRIMARY TOOTH
F FACIAL	G GOLD, CAST METAL, STAINLESS STEEL
L LINGUAL	N NON-METALLIC RESTORATION
M MESIAL	P PONTIC
O OCCLUSAL/INCISAL	R ROOT CANAL FILLING
U UNERUPTED	S SILVER AMALGAM
V VIRGIN TOOTH	T REMOVABLE PROS
X MISSING TOOTH	Z CARIES
/ JAW FRAGMENT	
MISSING, NONRECOGNIZABLE, FRACTURED CROWN, TRAUMATIC AVULSION	

X-Ray Type: _____	Date: _____
X-Ray Type: _____	Date: _____
X-Ray Type: _____	Date: _____
Examiners: _____	

1.	COMPUTER/DESCRIPTION CODES
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
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21.	
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25.	
26.	
27.	
28.	
29.	
30.	
31.	
32.	

REMARKS _____

DENTAL IDENTIFICATION SUMMARY REPORT

NAME OF DECEASED: _____ BODY NUMBER: _____
RANK: _____ SEX: _____ RACE: _____ AGE: _____ SSN: _____
EXAMINERS: _____ DATE: _____ PLACE: _____

COMPARISON OF ANTEMORTEM AND POSTMORTEM DENTAL RECORDS AND RADIOGRAPHS REVEAL CONCORDANCE ON TEETH NUMBER (DESCRIBE FEATURE)

1. _____	17. _____
2. _____	18. _____
3. _____	19. _____
4. _____	20. _____
5. _____	21. _____
6. _____	22. _____
7. _____	23. _____
8. _____	24. _____
9. _____	25. _____
10. _____	26. _____
11. _____	27. _____
12. _____	28. _____
13. _____	29. _____
14. _____	30. _____
15. _____	31. _____
16. _____	32. _____

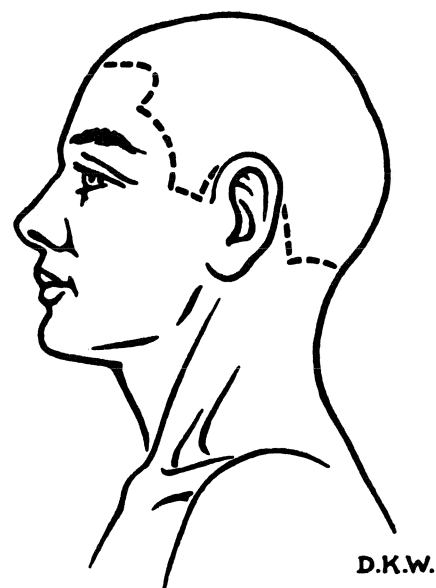
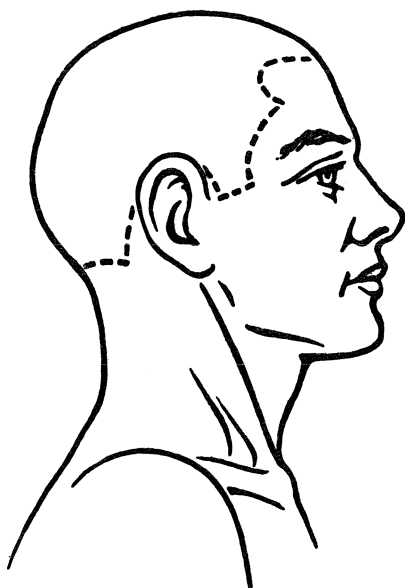
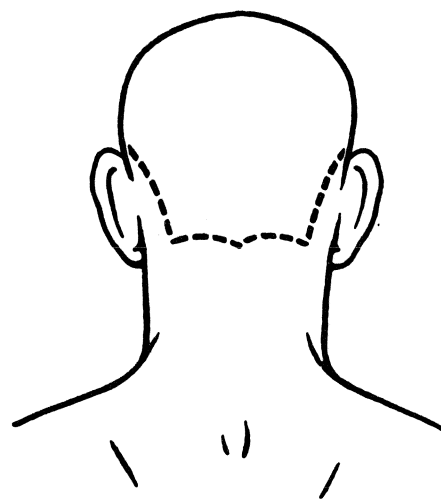
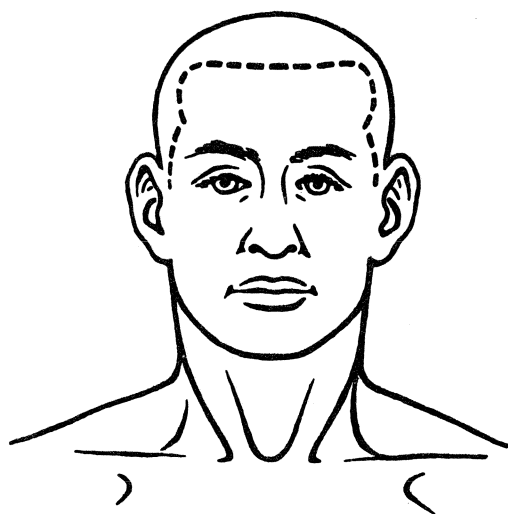
REMARKS: _____

FINDINGS (CIRCLE ONE) POSITIVE IDENTIFICATION CONSISTENT WITH UNIDENTIFIED

SIGNATURE OF EXAMINERS: _____

FINDINGS CONFIRMED BY: _____ (DENTAL TEAM LEADER)

CASE NO. _____ NAME _____



D.K.W.

DIAGRAM E

Figure 25 (21)

CASE NO. _____ NAME _____

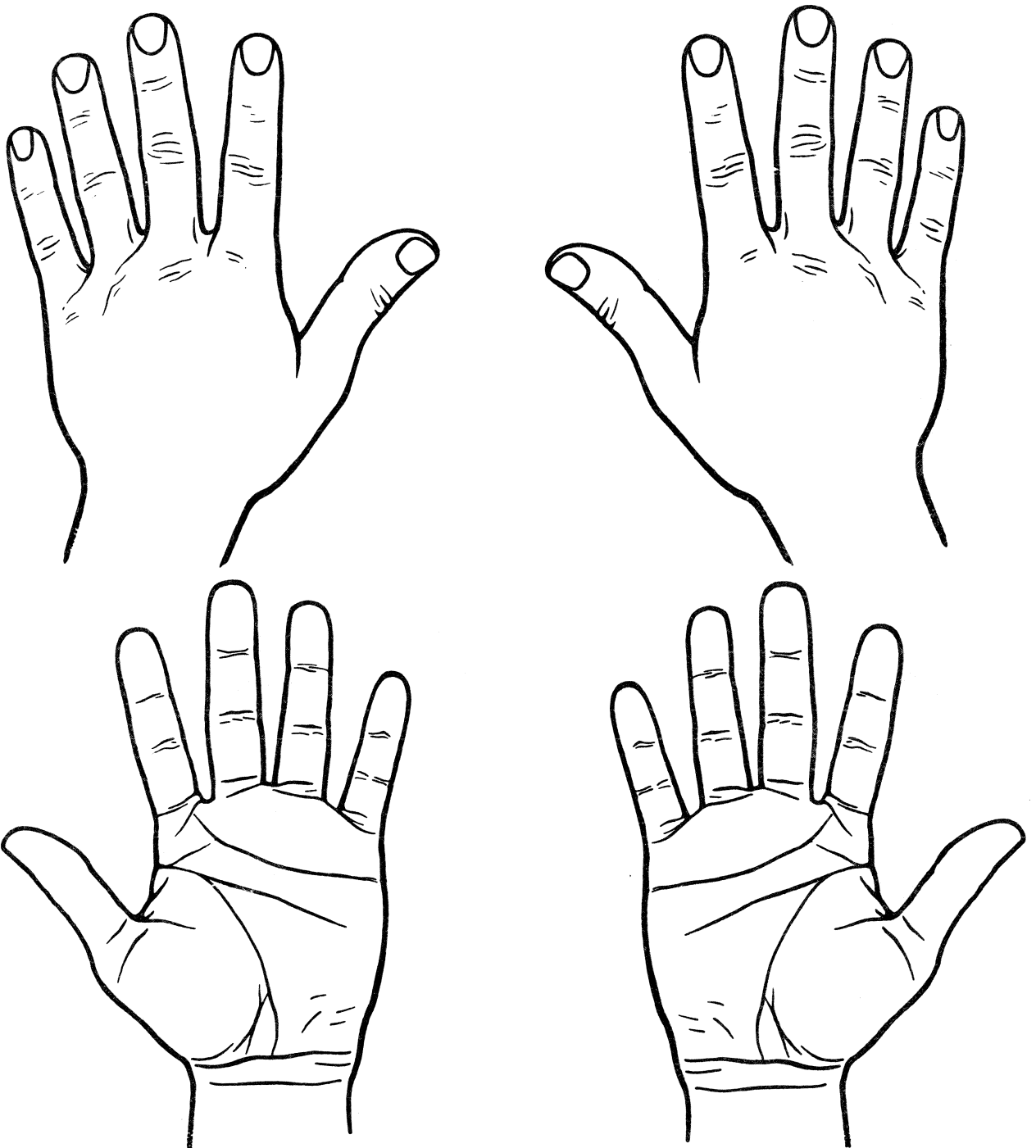
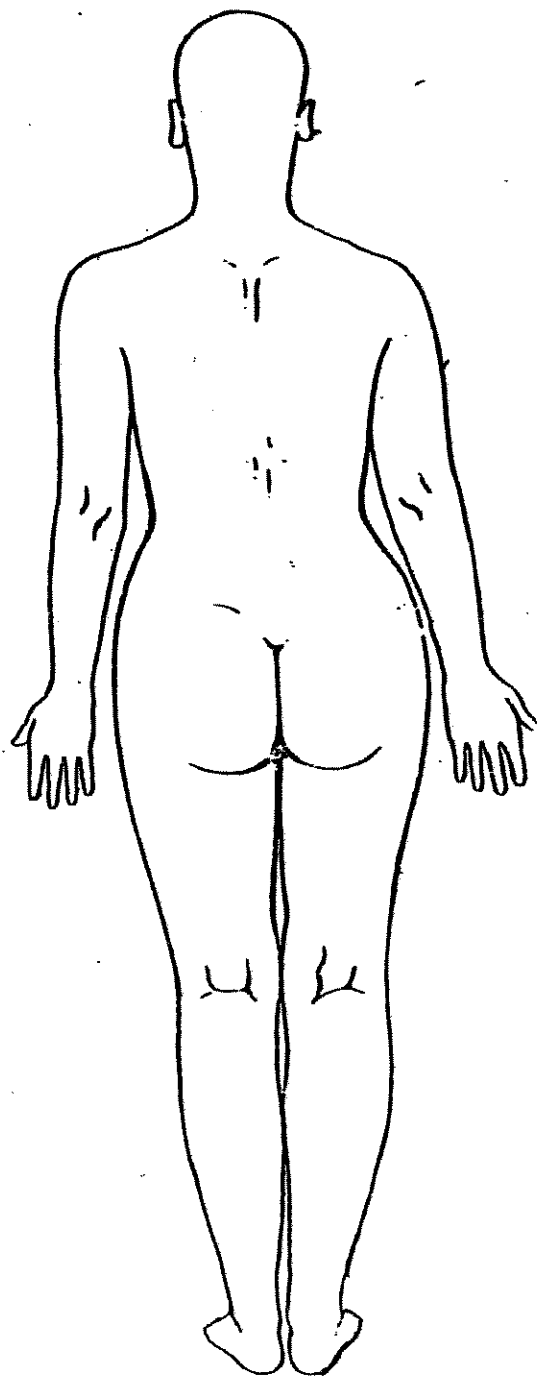
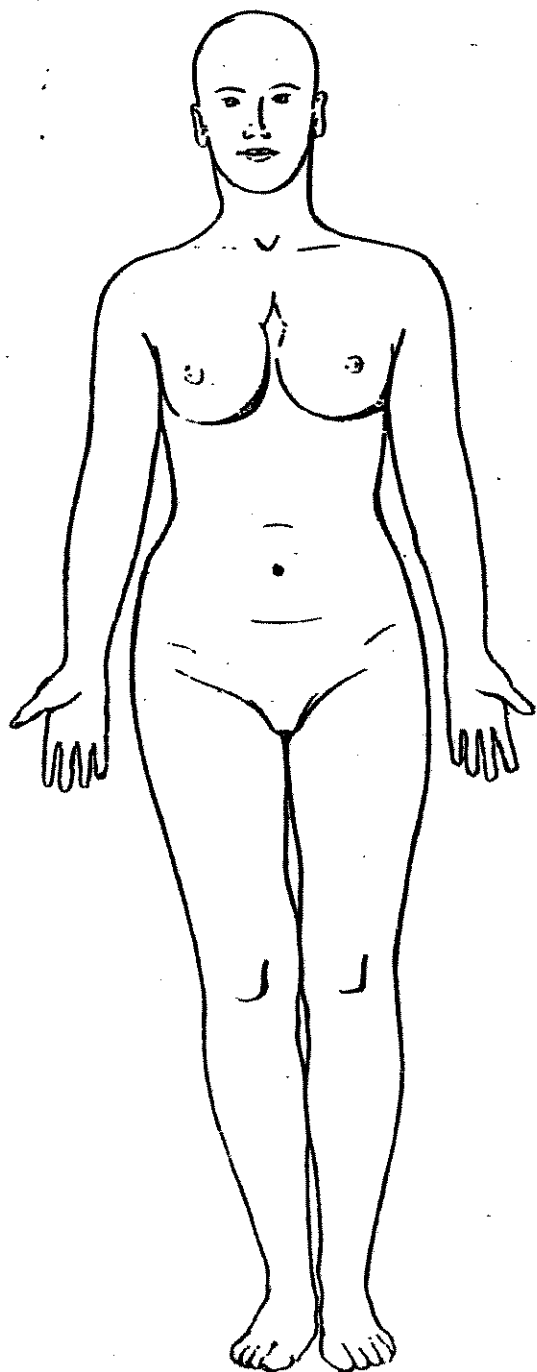


DIAGRAM F

Figure 25 (22)

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER

NAME: _____ DATE: _____ AUTOPSY NO. _____
SEX _____ RACE: _____ Case No. _____
HEIGHT _____ WEIGHT _____ EYE _____ HAIR _____



OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
FIREARM WOUND CHART

NAME _____ CASE NO. _____

		WOUND NO.											
		1		2		3		4		5		6	
		Ent.	Ex.	Ent.	Ex.	Ent.	Ex.	Ent.	Ex.	Ent.	Ex.	Ent.	Ex.
1. Location of wound:	Head												
	Neck												
	Chest												
	Abdomen												
	Back												
	Right												
	Arm < Left												
	Right												
2. Size of wound: INCHES	Diam.												
	Width												
	Length												
3. INCHES from wound to:	Top of head												
	Right of midline												
	Left of midline												
4. Firearm Residue:	On skin												
	Clothing												
	Absent												
5. Direction of missile through body:	Backward												
	Forward												
	Downward												
	Upward												
	To right												
	To left												
6. Missile Recovered:	Probable Calibre												
	Shotgun												

Photographs: _____ X-rays: _____

REMARKS:

Examiner: _____ Date: _____

CASE NO. _____ NAME _____

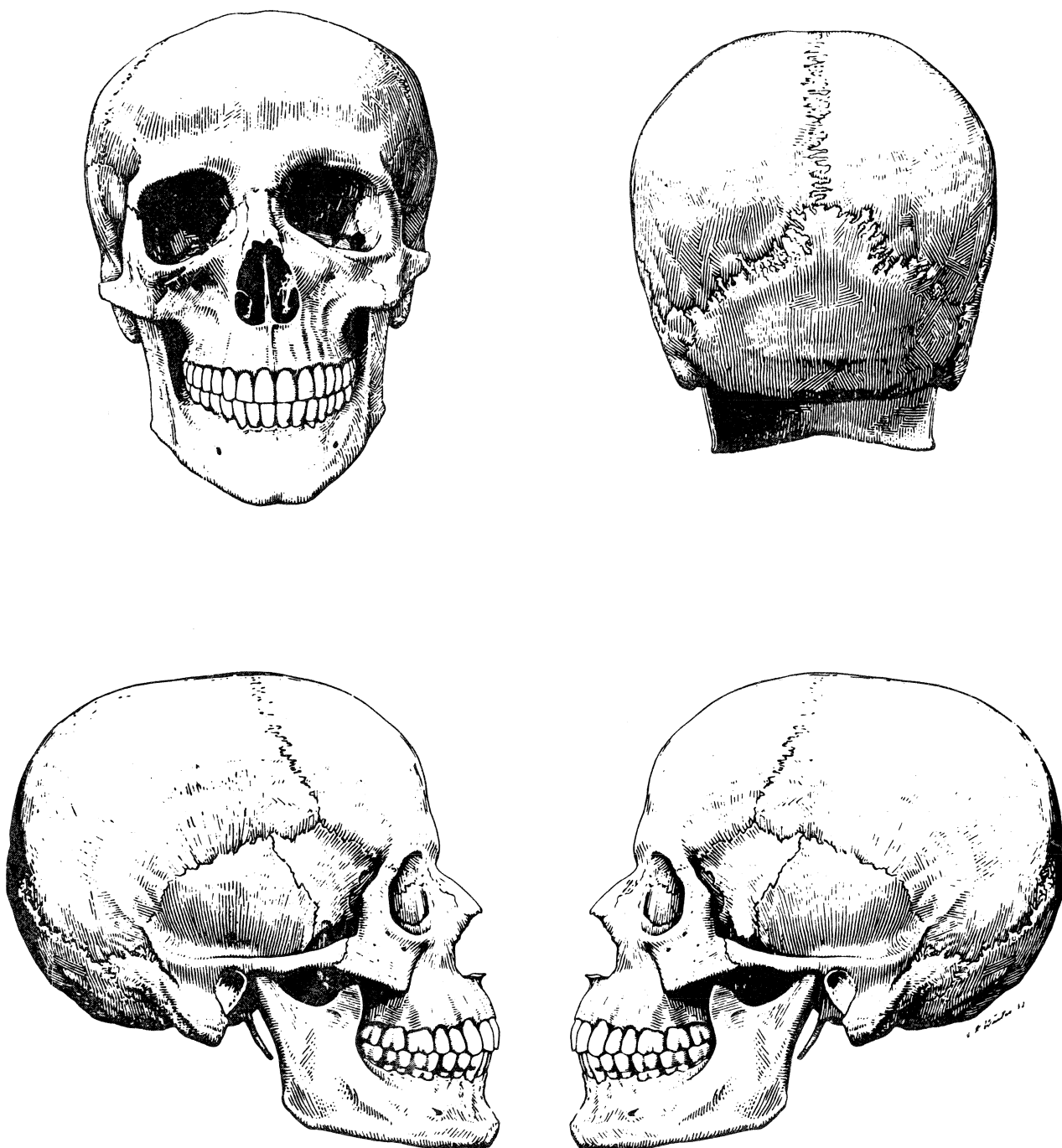


DIAGRAM G

Figure 25 (23)

CASE NO. _____ NAME _____

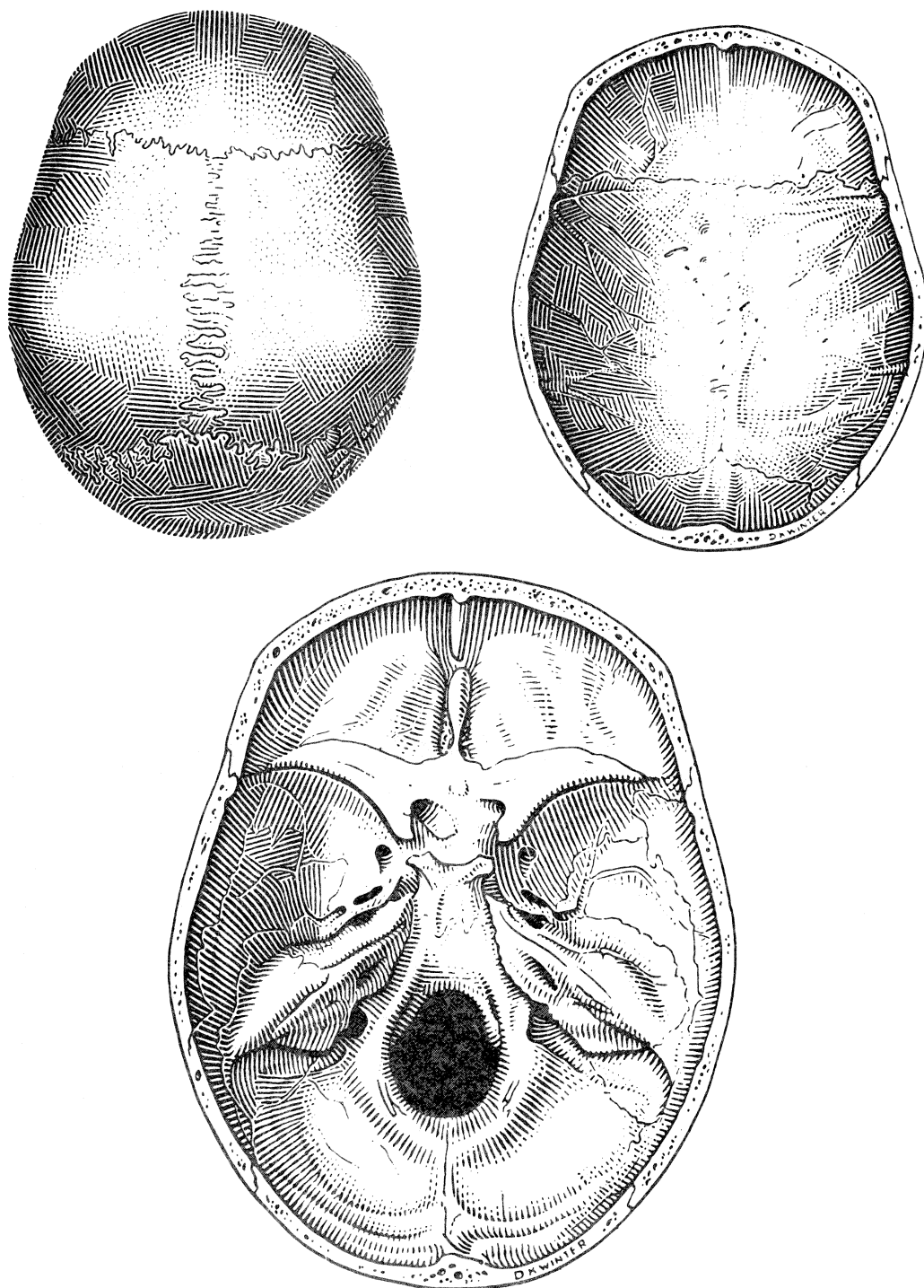


DIAGRAM H

Figure 25 (24)

CASE NO. _____ NAME _____

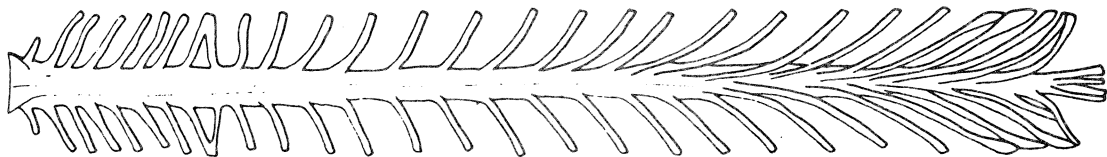
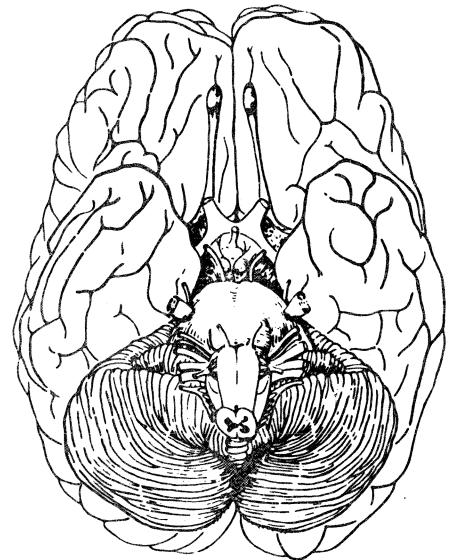
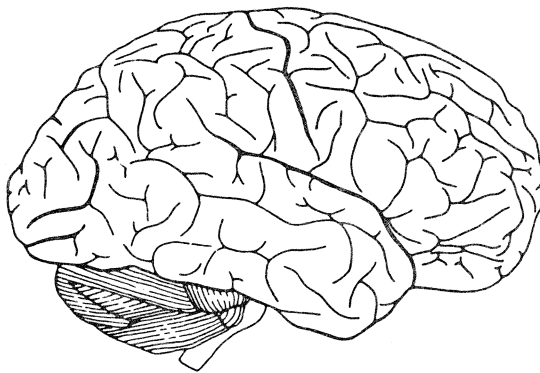
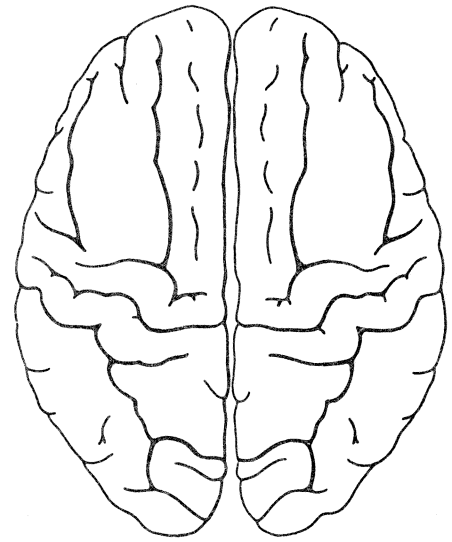
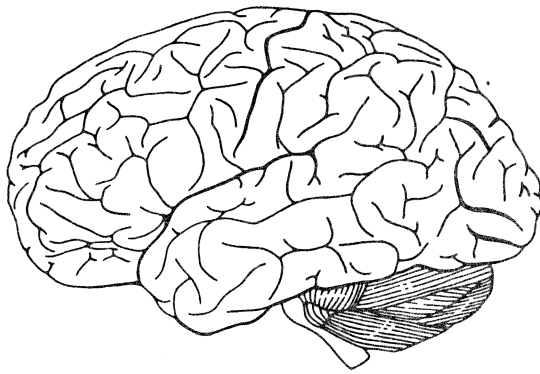


DIAGRAM I

Figure 25 (25)

CASE NO. _____ NAME _____

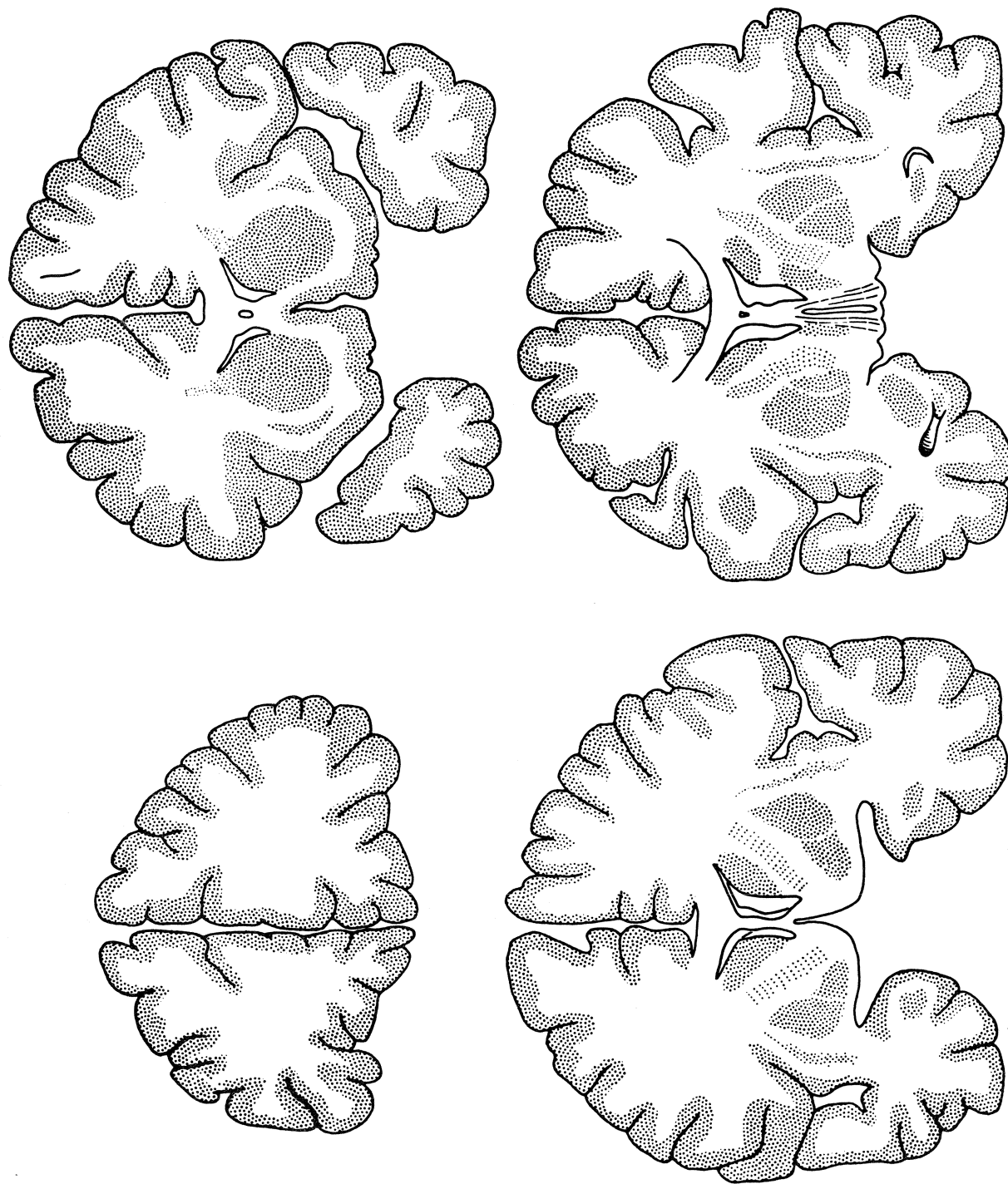


DIAGRAM J

CASE NO. _____ NAME _____

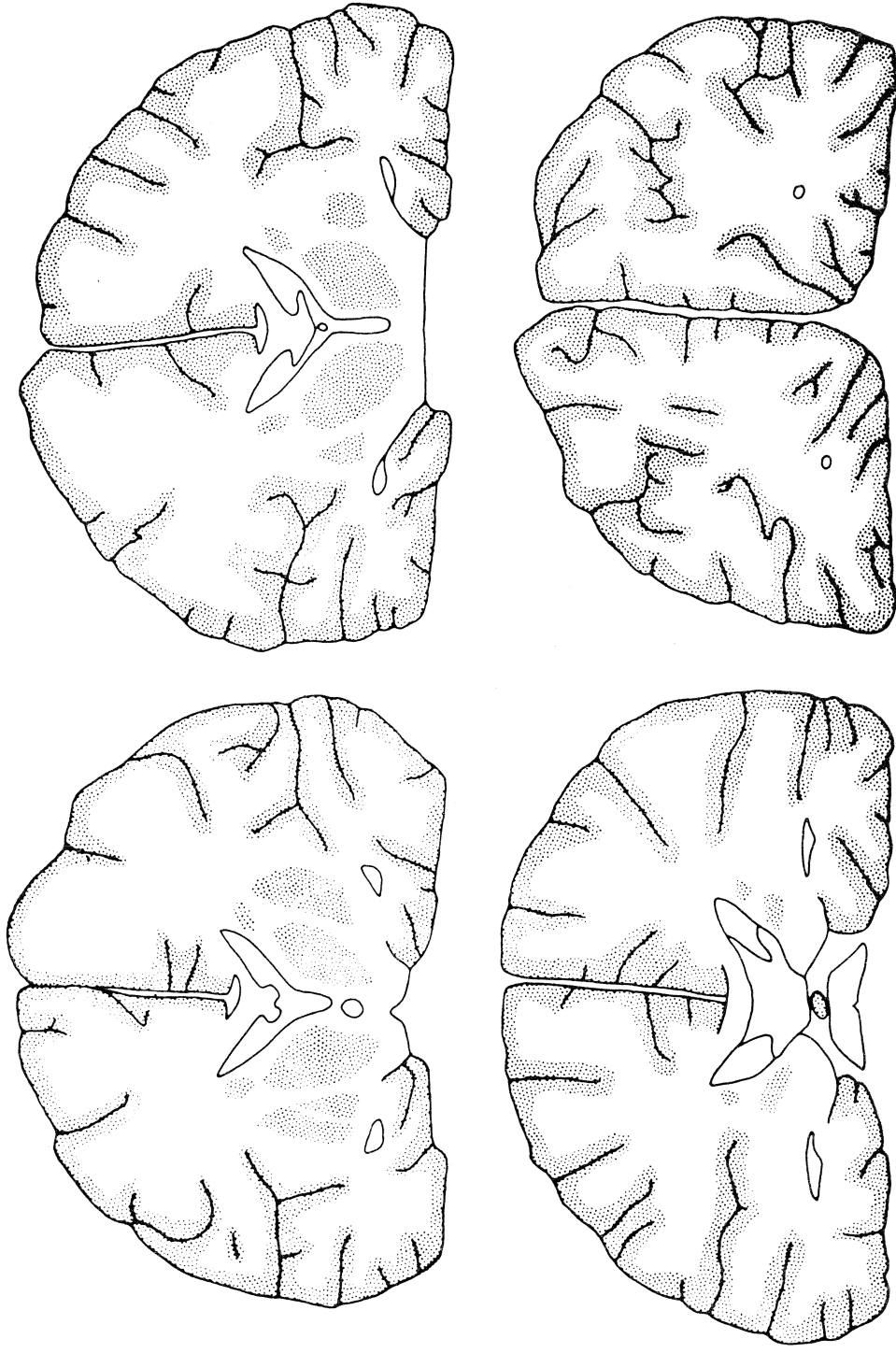
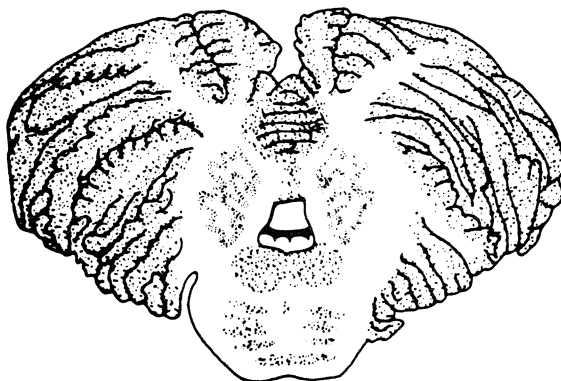
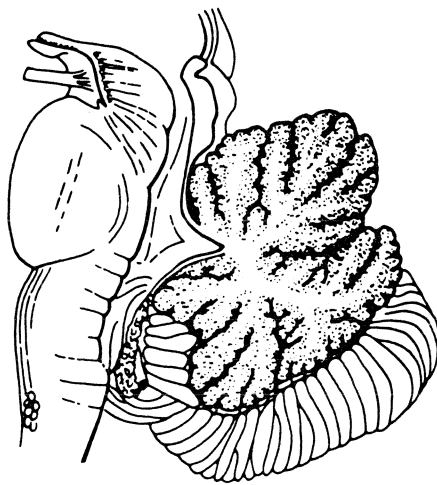
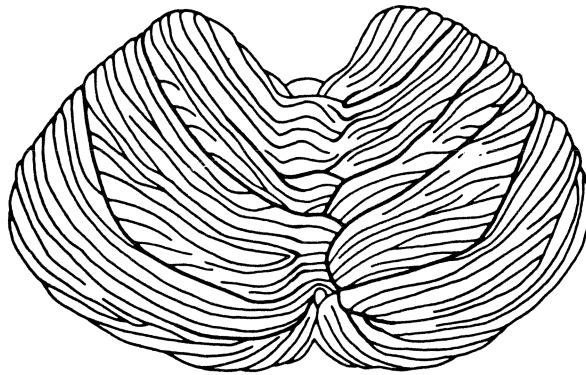
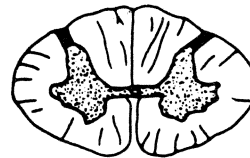


DIAGRAM K

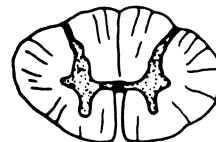
CASE NO. _____ NAME _____



C5



T2



T8



L3



S1



S3

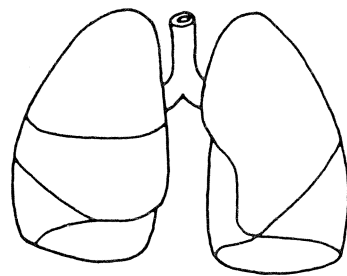


DIAGRAM L

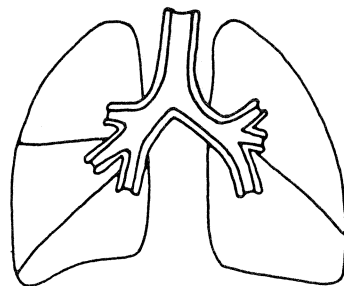
Figure 25 (28)

CASE NO. _____ NAME _____

RESPIRATORY SYSTEM



R L



CARDIOVASCULAR SYSTEM

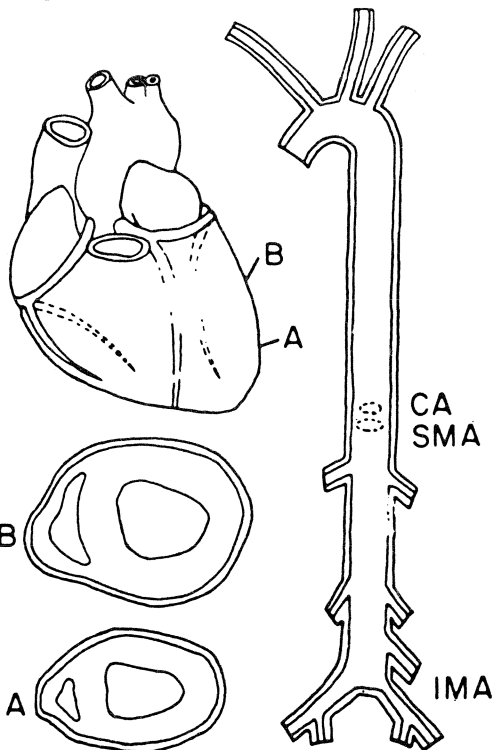
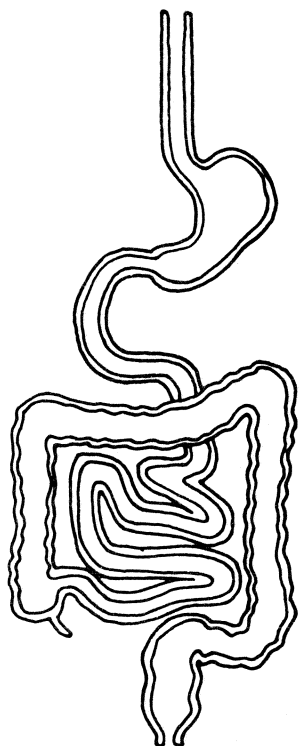


DIAGRAM M

Figure 25 (29)

CASE NO. _____ NAME _____

ALIMENTARY SYSTEM



BILIARY SYSTEM

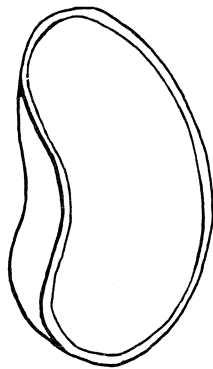
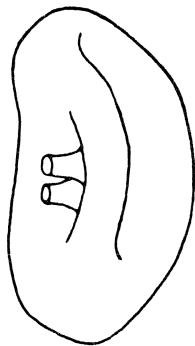


DIAGRAM N

Figure 25 (30)

CASE NO. _____ NAME _____

HEMATOPOIETIC SYSTEM



URINARY SYSTEM

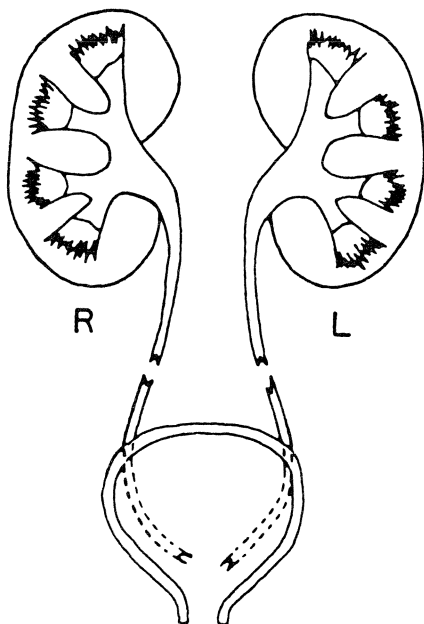


DIAGRAM O

DOB
Age
Sex
Height
Weight
D/F

CNS		Axial Skeleton								Liver and Biliary Tree	
Scalp		Right				Left				Liver	
		A	L	P	1	P	L	A			
		A	L	P	2	P	L	A			
		A	L	P	3	P	L	A	Gallbladder		
Skull		A	L	P	4	P	L	A	Biliary Tree		
		A	L	P	5	P	L	A			
		A	L	P	6	P	L	A			
		A	L	P	7	P	L	A			
		A	L	P	8	P	L	A			
		A	L	P	9	P	L	A			
Brain		A	L	P	10	P	L	A	Spleen		
		A	L	P	11	P	L	A	Pancreas		
		A	L	P	12	P	L	A	Adrenals		
Cervical spine									Genitourinary System		
1 2 3 4 5 6 7		Thoracic	1	2	3	4	5	R kidney g L kidney g			
		6	7	8	9	10	11	12			
		Lumbar	1	2	3	4	5				
Cord		Pelvis							Ureters		
									Bladder		
Neck		Lungs							Prostate/Uterus		
Strap Muscles		Right	g Left					g			
Thyroid Cartilage									Testes/Ovaries/Tubes		
Hyoid Cartilage									External		
Thyroid		Heart							Gastrointestinal		
Tongue									Teeth/Oral		
Vessels		L main	P					M	D		
		LAD									
		Left circumflex									
		Right									
		LV								Esophagus	
		RV								Stomach	cc
Body Cavities											
R Pleural cc		Aorta							Duodenum/Small bowel		
L Pleural cc											
Pericardial cc		Mesenteric							Colon		
Peritoneal cc		Renal									
RP cc		SVC/IVC							Appendix		
Trace: Blood Vitreous Liver Spleen Urine Gastric Brain Bile											
Cavity () blood Other Block Only Sections											

INTERNAL

CASE # _____

NAME: _____

PROSECTOR: _____

ASSISTANT: _____

SKIN: _____

BRAIN: _____ gm _____

NECK ORGANS: _____

THYROID: _____

PERICARDIAL SAC: _____

HEART: _____ gm _____

CORONARY ARTERIES: _____

AORTA: _____

PLEURAL CAVITIES: RIGHT _____ **LEFT** _____

RIGHT LUNG: _____ gm _____

LEFT LUNG: _____ gm _____

PERITONEAL CAVITY: _____

LIVER: _____ gm _____

GALLBLADDER: _____

PANCREAS: _____

STOMACH: _____

APPENDIX: _____

INTESTINES: _____

SPLEEN: _____ gm _____

ADRENALS: _____

RIGHT KIDNEY: _____ gm _____

LEFT KIDNEY: _____ gm _____

BLADDER: _____

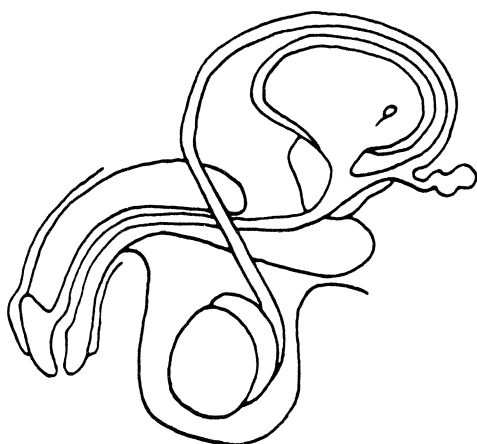
PROSTATE/TESTES: _____

UTERUS/OVARIES: _____

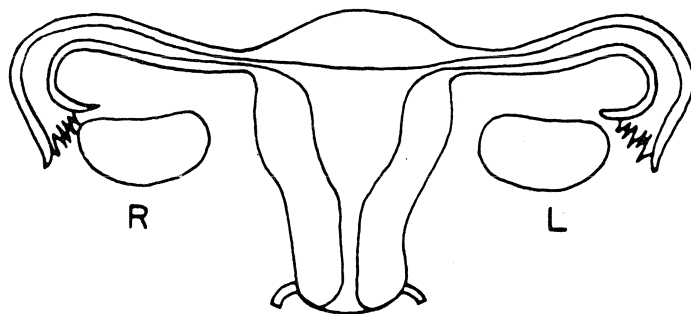
MUSCULOSKELETAL / VERTEBRAL COLUMN: _____

CASE NO. _____ NAME _____

MALE REPRODUCTIVE SYSTEM



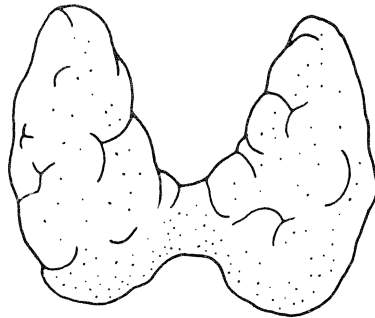
FEMALE REPRODUCTIVE SYSTEM



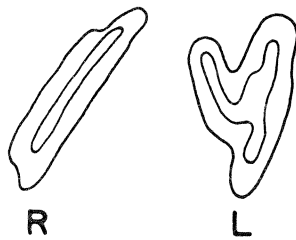
CASE NO. _____ NAME _____

ENDOCRINE SYSTEM

Thyroid



Adrenals



Pituitary

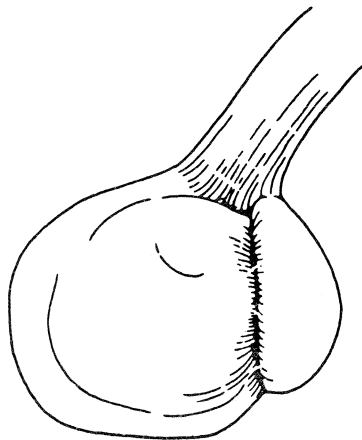


DIAGRAM Q

Figure 25 (33)

Reporting Form

SUIDI

Sudden Unexplained Infant Death Investigation

INVESTIGATION DATA

Infant's Information: Last: _____ First: _____ M. _____ Case# _____

Sex: ☐ Male ☐ Female Date of Birth _____ / _____ / _____ Age _____ SS# _____
Month Day Year

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

Infant's Primary Residence Address:

Address _____ City _____ Zip _____

Incident Address:

Address _____ City _____ Zip _____

Contact Information for Witness:

Relationship to the deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Grandfather
☐ Adoptive or Foster Parent ☐ Physician ☐ Health Records ☐ Other:

Last _____ First _____ M. _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Place of Work _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth _____

WITNESS INTERVIEW

1 Are you the usual caregiver? ☐ Yes ☐ No _____

2 Tell me what happened:

3 Did you notice anything unusual or different about the infant in the last 24 hrs? ☐ No ☐ Yes ⇨ Describe: _____

4 Did the infant experience any falls or injury within the last 72 hrs? ☐ No ☐ Yes ⇨ Describe: _____

5 When was the infant LAST PLACED? / / :
Month Day Year Military Time Location (room)

6 When was the infant **LAST KNOWN ALIVE (LKA)**? / / :
Month Day Year Military Time Location (room)

7 When was the infant **FOUND**? / / :
Month Day Year Military Time Location (room)

8 Explain how you knew the infant was still alive. _____

9 Where was the infant - (P)laced, (L)ast known alive, (F)ound (circle P, L, or F in front of appropriate response)?

P L F Bassinet	P L F Bedside co-sleeper	P L F Car seat	P L F Chair
P L F Cradle	P L F Crib	P L F Floor	P L F In a person's arms
P L F Mattress/box spring	P L F Mattress on floor	P L F Playpen	P L F Portable crib
P L F Sofa/couch	P L F Stroller/carriage	P L F Swing	P L F Waterbed
P L F Other _____			

WITNESS INTERVIEW (cont.)

- 10** In what position was the infant **LAST PLACED**?
Was this the infant's usual position? ☐ Yes ☐ No ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
☐ No $\Rightarrow$ What was the infant's usual position? _____
- 11** In what position was the infant **LKA**?
Was this the infant's usual position? ☐ Yes ☐ No ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
☐ No $\Rightarrow$ What was the infant's usual position? _____
- 12** In what position was the infant **Found**?
Was this the infant's usual position? ☐ Yes ☐ No ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
☐ No $\Rightarrow$ What was the infant's usual position? _____
- 13** **FACE** position when **LAST PLACED**? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left
- 14** **NECK** position when **LAST PLACED**? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned
- 15** **FACE** position when **LKA**? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left
- 16** **NECK** position when **LKA**? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned
- 17** **FACE** position when **FOUND**? ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left
- 18** **NECK** position when **FOUND**? ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned
- 19** What was the infant wearing? (ex. t-shirt, disposable diaper) _____
- 20** Was the infant tightly wrapped or swaddled? ☐ No ☐ Yes $\Rightarrow$ Describe: _____

21 Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

Bedding UNDER Infant	None	Number	Bedding OVER Infant	None	Number
Receiving blankets	☐	_____	Receiving blankets	☐	_____
Infant/child blankets	☐	_____	Infant/child blankets	☐	_____
Infant/child comforters (thick)	☐	_____	Infant/child comforters (thick)	☐	_____
Adult comforters/duvets	☐	_____	Adult comforters/duvets	☐	_____
Adult blankets	☐	_____	Adult blankets	☐	_____
Sheets	☐	_____	Sheets	☐	_____
Sheepskin	☐	_____	Pillows	☐	_____
Pillows	☐	_____	Rubber or plastic sheet	☐	_____
Rubber or plastic sheet	☐	_____	Other, specify:	_____	_____
Other, specify:	_____	_____			

- 22** Which of the following devices were operating in the infant's room?
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air Purifier ☐ Other _____
- 23** What was the temperature of the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other _____
- 24** What was the infant's temperature? _____
- 25** Which of the following items were near the infant's face, nose, or mouth?
☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other _____
- 26** Which of the following items were within the infant's reach?
☐ Pacifier ☐ Nothing ☐ Other _____
☐ Blankets ☐ Toys ☐ Pillows _____
- 27** Was anyone sleeping with the infant? ☐ No ☐ Yes $\Rightarrow$ Name these people. _____
- | Name | Age | Height | Weight | Location in Relation to Infant | Impaired (intoxicated, tired) |
|-------|-------|--------|--------|--------------------------------|-------------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
- 28** Was there evidence of wedging? ☐ No ☐ Yes $\Rightarrow$ Discribe: _____
- 29** When the infant was found, was s/he: ☐ Breathing ☐ Not breathing
If not breathing, did you witness the infant stop breathing? ☐ No ☐ Yes

INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant's life, did s/he have a history of?

	Unknown	No	Yes	Describe:
a) Allergies (food, medication, or other)	☐	☐	☐	⇒ _____
b) Abnormal growth or weight gain/loss	☐	☐	☐	⇒ _____
c) Apnea (stopped breathing)	☐	☐	☐	⇒ _____
d) Cyanosis (turned blue/gray)	☐	☐	☐	⇒ _____
e) Seizures or convulsions	☐	☐	☐	⇒ _____
f) Cardiac (heart) abnormalities	☐	☐	☐	⇒ _____
g) Metabolic disorders	☐	☐	☐	⇒ _____
h) Other	☐	☐	☐	⇒ _____

6 Did the infant have any birth defects(s)?

☐ No ☐ Yes

Describe: _____

7 Describe the two most recent times that the infant was seen by a physician or health care provider:

(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

	First most recent visit	Second most recent visit
a) Date	_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year
b) Reason for visit	_____	_____
c) Action taken	_____	_____
d) Physician's name	_____	_____
e) Hospital/clinic	_____	_____
f) Address	_____	_____
g) City, ZIP	_____	_____
h) Phone number	() - _____	() - _____

8 Birth hospital name:

Street _____

City _____ State _____ ZIP _____

Date of discharge ____/____/____
Month Day Year

9 What was the infant's length at birth? _____ inches _____ or _____ centimeters

10 What was the infant's weight at birth? _____ pounds _____ ounces _____ or _____ grams

11 Compared to the delivery date, was the infant born on time, early, or late?

☐ On time ☐ Early - How many weeks early? _____ ☐ Late - How many weeks late? _____

12 Was the infant a singleton, twin, triplet, or higher gestation?

☐ Singleton ☐ Twins ☐ Triplet ☐ Quadruplet or higher gestation

13 Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen)

☐ No ☐ Yes ⇒ Describe the complications: _____

14 Are there any alerts to pathologist? (previous infant deaths in family, newborn screen results)

☐ No ☐ Yes ⇒ Specify: _____

INFANT DIETARY HISTORY

1 On what day and at what approximate time was the infant last fed?

____/____/____ :____
Month Day Year Military Time

2 What is the name of the person who last fed the infant? _____

3 What is his/her relationship to the infant? _____

4 What foods and liquids was the infant fed in the **last 24 hours** (include last fed)?

	Unknown	No	Yes		Quantity	Specify: (type and brand if applicable)
a) Breast milk (one/both sides, length of time)	☐	☐	☐	⇒	_____ ounces	_____
b) Formula (brand, water source - ex. Similac, tap water)	☐	☐	☐	⇒	_____ ounces	_____
c) Cow's milk	☐	☐	☐	⇒	_____ ounces	_____
d) Water (brand, bottled, tap, well)	☐	☐	☐	⇒	_____ ounces	_____
e) Other liquids (teas, juices)	☐	☐	☐	⇒	_____ ounces	_____
f) Solids	☐	☐	☐	⇒	_____	_____
g) Other	☐	☐	☐	⇒	_____	_____

5 Was a new food introduced in the 24 hours prior to his/her death?

☐ No ☐ Yes ⇒ Describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle?

☐ Yes ☐ No ⇒ Skip to question **9** below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds)

☐ No ☐ Yes ⇒ What object was used to prop the bottle? _____

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

9 Did death occur during? ☐ Breast-feeding ☐ Bottle-feeding ☐ Eating solid foods ☐ Not during feeding

10 Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)

☐ No ☐ Yes ⇒ Describe concerns: _____

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name _____ Middle name _____

Last name _____ Maiden name _____

Date of birth: _____ SS # _____
Month / Day / Year

Current Address _____ City _____ State _____ ZIP _____

How long has the birth mother been a resident at this address? _____ and _____
Years Months Previous Address City State

2 At how many weeks or months did the birth mother begin prenatal care?

_____ Weeks _____ Months ☐ No prenatal care ☐ Unknown

3 Where did the birth mother receive prenatal care? (Please specify physician or other health care provider name and address.)

Physician/provider _____ Hospital/clinic _____ Phone (____) _____

Street _____ City _____ State _____ ZIP _____

PREGNANCY HISTORY (cont.)

4 During her pregnancy with the infant, did the biological mother have any complications?

(ex. high blood pressure, bleeding, gestational diabetes)

☐ No ☐ Yes ⇨ Specify _____

5 Was the biological mother injured during her pregnancy with the infant? (ex. auto accident, falls)

☐ No ☐ Yes ⇨ Specify _____

6 During her pregnancy, did she use any of the following?

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

7 Currently, does any caregiver use any of the following?

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur? _____

2 Was this the primary residence? _____

☐ Yes ☐ No

3 Is the site of the incident or death scene a daycare or other childcare setting?

☐ Yes ☐ No ⇨ Skip to question **8** below

4 How many children were under the care of the provider at the time of the incident or death? _____ (under 18 years or older)

5 How many adults were supervising the child(ren)? _____ (18 years or older)

6 What is the license number and licensing agency for the daycare?

License number: _____

Agency: _____

7 How long has the daycare been open for business? _____

8 How many people live at the site of the incident or death scene?

_____ Number of adults (18 years or older)

_____ Number of children (under 18 years old)

9 Which of the following heating or cooling sources were being used? (Check all that apply.)

☐ Central air	☐ Gas furnace or boiler	☐ Wood burning fireplace	☐ Open window(s)
☐ A/C window unit	☐ Electric furnace or boiler	☐ Coal burning furnace	☐ Wood burning stove
☐ Ceiling fan	☐ Electric space heater	☐ Kerosene space heater	
☐ Floor/table fan	☐ Electric baseboard heat	☐ Other ⇨ Specify _____	
☐ Window fan	☐ Electric (radiant) ceiling heat	☐ Unknown	

10 Indicate the temperature of the room where the infant was found unresponsive:

_____ Thermostat setting _____ Thermostat reading _____ Actual room temp. _____ Outside temp.

11 What was the source of drinking water at the site of the incident or death scene? (Check all that apply.)

☐ Public/municipal water source	☐ Bottled water	☐ Other ⇨ Specify _____
☐ Well	☐ Unknown	

12 The site of the incident or death scene has: (check all that apply)

☐ Insects	☐ Mold growth	☐ Odors or fumes ⇨ Describe: _____
☐ Smoky smell (like cigarettes)	☐ Pets	☐ Presence of alcohol containers
☐ Dampness	☐ Peeling paint	☐ Presence of drug paraphernalia
☐ Visible standing water	☐ Rodents or vermin	☐ Other ⇨ Specify _____

13 Describe the general appearance of incident scene: (ex. cleanliness, hazards, overcrowding, etc.)

INVESTIGATION SUMMARY

- 1** Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

2 Arrival times: Law enforcement at scene: : DSI at scene: : Infant at hospital: :
Military Time Military Time Military Time

Investigator's Notes

Indicate the task(s) performed.

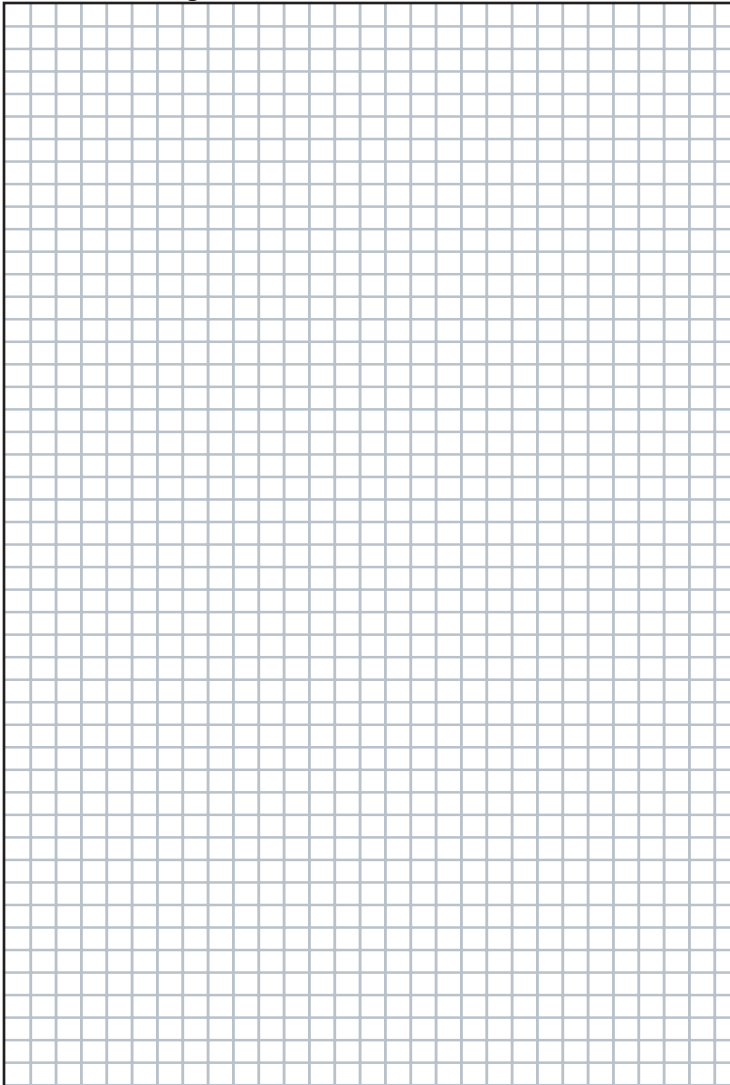
- | | | |
|--|---|--|
| ☐ Additional scene(s)? (forms attached) | ☐ Doll reenactment/scene re-creation | ☐ Photos or video taken and noted |
| ☐ Materials collected/evidence logged | ☐ Referral for counseling | ☐ EMS run sheet/report |
| ☐ Notify next of kin or verify notification | ☐ 911 tape | |

If more than one person was interviewed, does the information differ?

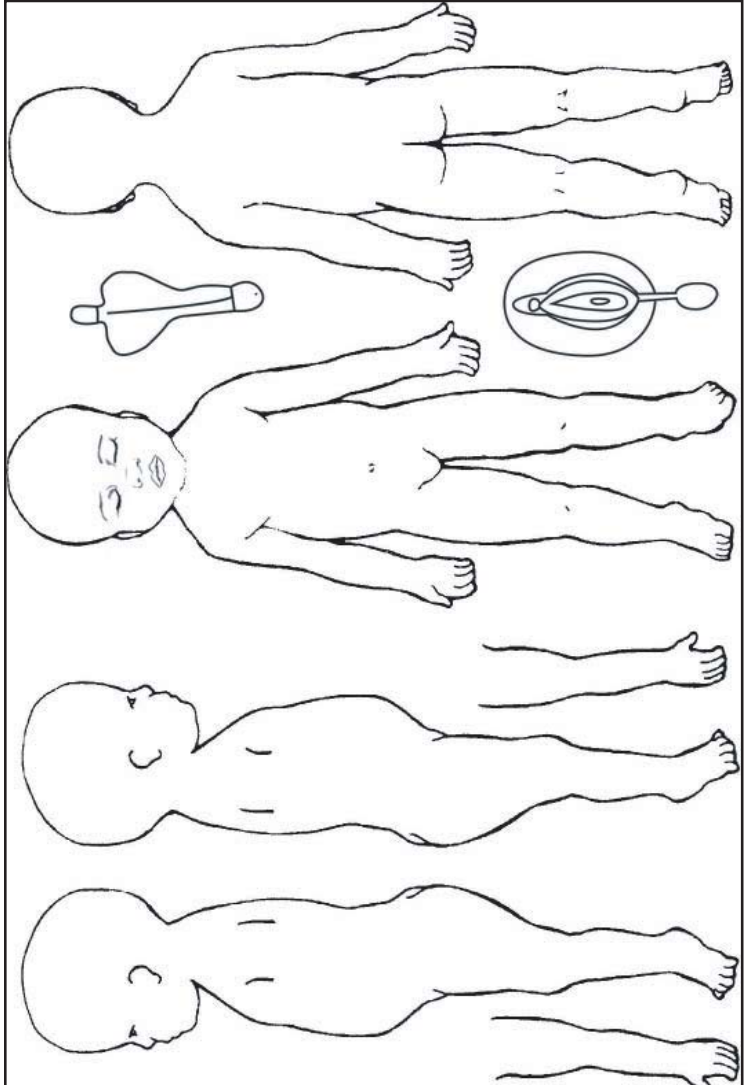
- ☐ No ☐ Yes ⇨ Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

1 Scene Diagram:



2 Body Diagram:



SUMMARY FOR PATHOLOGIST

Case Information

Investigator Information: Name _____ Agency _____ Phone _____
 Investigated: _____ / _____ / _____ : _____ Pronounced Dead: _____ / _____ / _____ : _____
 Month Day Year Military Time Month Day Year Military Time
Infant's Information: Last _____ First _____ M. _____ Case # _____
 Sex: ☐ Male ☐ Female Date of Birth _____ / _____ / _____ Age _____
 Month Day Year Months
 Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

Yes No

- ☐ ☐ Asphyxia (ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)
- ☐ ☐ Sharing of sleeping surface with adults, children, or pets
- ☐ ☐ Change in sleeping condition (ex. unaccustomed stomach sleep position, location, or sleep surface)
- ☐ ☐ Hyperthermia/Hypothermia (ex. excessive wrapping, blankets, clothing, or hot or cold environments)
- ☐ ☐ Environmental hazards (ex. carbon monoxide, noxious gases, chemicals, drugs, devices)
- ☐ ☐ Unsafe sleeping conditions (ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)

Infant History

- ☐ ☐ Diet (e.g., solids introduction etc.)
- ☐ ☐ Recent hospitalization
- ☐ ☐ Previous medical diagnosis
- ☐ ☐ History of acute life-threatening events (ex. apnea, seizures, difficulty breathing)
- ☐ ☐ History of medical care without diagnosis
- ☐ ☐ Recent fall or other injury
- ☐ ☐ History of religious, cultural, or ethnic remedies
- ☐ ☐ Cause of death due to natural causes other than SIDS (ex. birth defects, complications of preterm birth)

Family Info

- ☐ ☐ Prior sibling deaths
- ☐ ☐ Previous encounters with police or social service agencies
- ☐ ☐ Request for tissue or organ donation
- ☐ ☐ Objection to autopsy

Exam

- ☐ ☐ Pre-terminal resuscitative treatment
- ☐ ☐ Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

- ☐ ☐ Suspicious circumstances
- ☐ ☐ Other alerts for pathologist's attention

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

Pathologist

2 Pathologist Information:

Name _____ Agency _____
 Phone (_____) _____ - _____ Fax (_____) _____ - _____