

State of Arkansas



County of Lonoke
Office of Coroner

CORONER'S SUBPOENA

In reference to the following death occurring on or about the _____ day of _____ in
Lonoke County, Arkansas:

Decedent:

SAMPLE - DRAFT

Social Security Number:

Date of Birth:

To:

Phone/Fax:

Address:

Under the authority of Ark. Code Ann. Sec. 14-15-302 (2):

YOU ARE COMMANDED to produce at the time, date, and place set forth below legible copies of the following documents, electronically stored information, x-rays or other objects as described:

Date and Time to be Surrendered:

Acceptable method of providing requested documents:

Witness my hand and seal this _____ day of _____ .

Office of Lonoke County Coroner

P.O. Box 510

Cabot AR 72023

501-405-2381

SAMPLE - DRAFT - VOID

Mark A. Thomas, Lonoke County Coroner

Benton County, Arkansas Medicolegal Death Investigation

Coroner, D Oxford (ABMDI)

FAX: 479-621-9076

Office: 479-621-0223
Cell: 479-925-8021

Prescription Inventory

*** Please fax to the Coroner's office within 24 hrs to 479-621-9076 ***

Decedents Name: _____

DOB:

Date:

Law Enforcement Agency: _____

Officer Receiving Form:

By Coroner:

Law Enforcement CR#:

Coroner CR#:

Please include information on empty bottles as well as filled bottles

[illegible]

Medicolegal Death Investigator (Coroner) Put date and time form given to Law Enforcement

Inventory Officer signature

Date:

Witness

Date & Time Form given to law Enforcement to complete:



Daniel R Oxford D-ABDMI

Medicolegal Investigations

Chief Deputy Coroner M. Bates

Administrative Assistant T. Ward

Photo Log

Date Photos Taken: _____

Coroner Cr #: _____

Name of Deceased: _____ DOB: _____

[illegible]

*** Not all Photos taken by Coroner's Office maybe listed above, Log shows close up photos for identification of injuries, Locations & etc. ***

Page Of

Initials of person completing Log



Subpoena



Office of the Coroner, Benton County Arkansas

State of Arkansas
County of Benton
Office of the Coroner

2501 N. 4th St. Suite D
Rogers Ar. 72756
Office 479-621-0223
Fax 479-621-9076

In reference to the death of:

Sample

Occurring on or about the

_____ day of, _____ 20 _____, In Benton County Arkansas

Subpoena is directed to

- ☐ You are hereby directed to attend and give testimony as a witness in the above described matter.

Date & Time to Appear

Location of Appearance

- ☐ You are hereby directed to bring any and all books, papers, documents, x-rays or other tangible items described below

Description

Date & Time of Delivery/Release

Location of Delivery/Release

- ☐ You are hereby directed to surrender and release to the Office of Coroner, any and all books, papers, documents, x-rays, or other tangible items described below

Description

Date & Time of Delivery/Release

☐ **Pick up In Person**

☐ Fax To (479) 621-9076

☐ Mail To Coroner

This Subpoena is under the authority of Arkansas Code Annotated, Section 14-15-302 in the investigation of this death.

Witness my hand on this

_____ day of, _____, 20 _____

VOID

Daniel R. Oxford, Coroner Benton County

Received:

☐ Fax

☐ In Person

☐ Email

Date & Time Received:

Representative of:

Received By: (Signature)

Benton County Coroner Field Investigation Information & Medical History / Accident(s) / Injury Questionnaire

Coroner CR #:		Coroner:	
Name Of Deceased:		DOB:	
Social Security #:		DL #:	
Sex:	☐ Male ☐ Female ☐ Unk	Funeral Home Information:	
Person Providing Medical History:			
Name:		Relationship:	
Address:		City:	State:
Contact Numbers:			
Medical History			
☐ Yes ☐ No	Diabetes	Physician:	
☐ Yes ☐ No	Hypertension / Hypotension		
☐ Yes ☐ No	Dementia / Alzheimer's	Diagnosed Date:	
☐ Yes ☐ No	Pregnant at this time	Date of Last known Pregnancy:	
☐ Yes ☐ No	COPD / Pneumonia / Respiratory Failure	On Oxygen: ☐ Yes ☐ No	
☐ Yes ☐ No	Dizziness / Weakness / Vomiting	Date:	
☐ Yes ☐ No	Cancer	Type:	Dr:
☐ Yes ☐ No	Complaining of Chest tightness / Chest pain	Date:	
☐ Yes ☐ No	Heart Attacks / Stints / Bi Pass / ETC.	Approximate Dates:	
☐ Yes ☐ No	CVA History	Did it Change way of life:	☐ Yes ☐ No
☐ Yes ☐ No	Surgery	Date:	Reason:
☐ Yes ☐ No	CHF	Depression: ☐ Yes ☐ No	
☐ Yes ☐ No	Kidney Failure / Liver Failure	Dialysis: ☐ Yes ☐ No	
☐ Yes ☐ No	Allergies (Food, Medications, ETC.)	Explain:	
☐ Yes ☐ No	Falls or Fell	Required Medical treatment	☐ Yes ☐ No
☐ Yes ☐ No	Long Bone Fractures	Date:	Dr:
☐ Yes ☐ No	MVA's	Date:	Injuries: ☐ Yes ☐ No
☐ Yes ☐ No	Physical Altercation	Date:	Injuries: ☐ Yes ☐ No
☐ Yes ☐ No	Previous Suicide Attempts	Date(s):	
☐ Yes ☐ No	Has deceased ever Overdosed on Rx's or Alcohol	Date(s):	
☐ Yes ☐ No	Hx of Subdural Hematomas	Date(s):	
☐ Yes ☐ No	Hepatitis / MRSA / STD's / Auto Immune Deficiency	Date:	
☐ Yes ☐ No	Use Of Recreational Drugs	Type Used:	
☐ Yes ☐ No	Abused (s) Rx Medication	Type Abused:	
Deceased Diagnosed W/ Agent Orange:		☐ Yes ☐ No ☐ Unk	When/Where:
Tobacco Use:	☐ Yes ☐ No ☐ Unk	Type used:	Amount:
Alcohol use:	☐ Yes ☐ No ☐ Unk	Been Diagnosed with Alcoholism:	☐ Yes ☐ No ☐ Unk
Chemical Exposure / Causing Health Issues:		☐ Yes ☐ No ☐ Unk	Date:
Date Deceased last seen alive:		Time:	
Deceased Normal Bed time & Location He/She sleeps:			
Employment Information & Location:			
Is Abuse, Neglect, Domestic abuse or Foul Play Suspected:		☐ Yes ☐ No ☐ Unk ☐ Pending Invest.	
Autopsy Requested:		☐ Yes ☐ No	By Whom:
Agency Completing Body submission:			
Signature of Person supplying Information:			
Coroner Signature:			



Benton County Coroner's Office



2501 N. 4th St. Suite D
Rogers Arkansas 72756
(479) 621-0223 Office / Fax (479) 621-9076

Authorization to Cremate Deceased

(Cremation Requested by Family, before Death Certificate is signed)

Date of Request: _____ Date / Time of Pronounce: _____
Funeral Home: _____ Coroner / Deputy Coroner assigned case: _____
Funeral Director: _____
Name of Deceased: SAMPLE
Date of Birth: _____
Social Security (if known): _____

Reason for Request (i.e., Religious reason, Weekend, D/C not ready, etc.): _____

At this time it appears no additional Coroner or Law Enforcement investigation is being conducted regarding the death of the above named person, No holds have been placed on the remains by the Coroner's Office or the Law Enforcement agency of the jurisdiction where the death occurred. At this time NO outside Law Enforcement agency has contacted the Coroner's office with any concerns or questions regarding the death of the above named.

On the _____ day of _____, 20____, The Benton County Coroner's Office is releasing the remains of: _____, our findings show No reason to delay the cremation while waiting for the Death Certificate to be signed, As long the following is followed:

- The Funeral Home and the Funeral Director named above is required to hold the above named deceased for 24 hrs after the Coroner / Deputy Coroner Pronounce time. **Unless the Following apply, and MUST have Coroner D. Oxford Approval:**
 - Due to a Religious Belief , (i.e. cremated before sun down, etc). Must be approved by Coroner Daniel R. Oxford.
 - Due to Extreme Decomposition of Remains, causing health concerns for funeral home personal. Must be approved by Coroner Daniel R. Oxford.
 - Or any other reason(s) the Coroner decides is an exception.

VOID

Coroner Daniel R. Oxford or Deputy Coroner

Title

Date/Time

(Deputy Coroner's MUST HAVE Coroner Daniel Oxford Verbal Permission to sign)



Benton County Coroner's Office



2501 N. 4th St. Suite D
Rogers Arkansas 72756
(479) 621-0223 Office / Fax (479) 621-9076

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VOID

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ADDITIONAL INVESTIGATIVE SCENE FORMS

Table of Contents

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Infant's Information

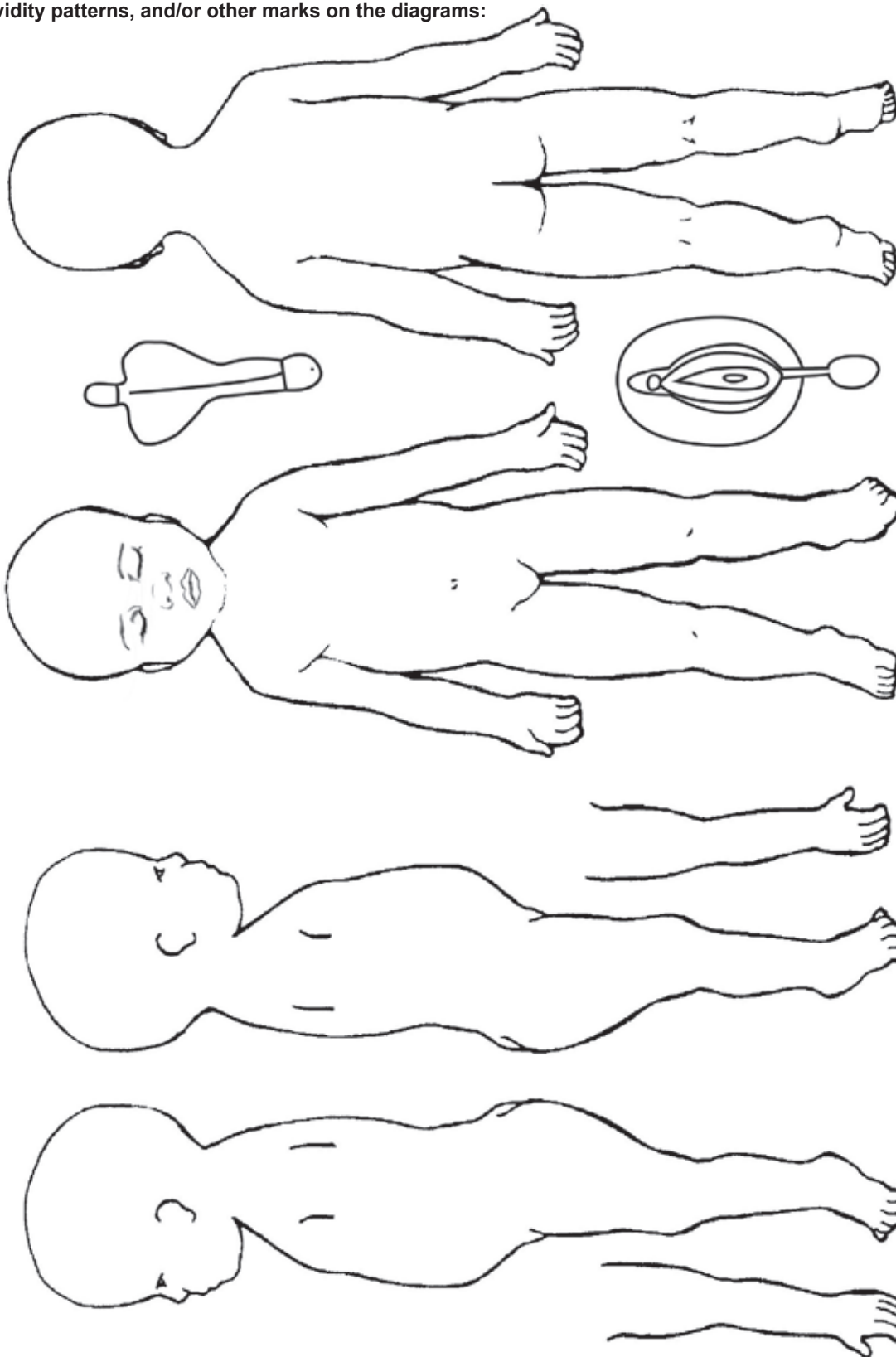
Last Name

First Name

Middle

Case Number

1 Draw lividity patterns, and/or other marks on the diagrams:



A - BODY DIAGRAM

Section Completed by (name)

Month

Day

Year

Military Time

In person

Telephone

Other

Infant's Information

Last Name	First Name	Middle	Case Number

1 Information about the EMS responder:

Last name	First name	Agency

Date/Time Dispatched:	Month	Day	Year	Military Time
				:

2 Who called 911?

Last name	First name	Relationship (example aunt)

3 What date and time did you arrive?

Month	Day	Year	Military Time
			:

4 Was anyone doing CPR when EMS arrived?

No	Yes	Who?

5 Where was the infant when you arrived at the scene? (ex. crib, arms of caregiver)

--

6 Describe infant's appearance when found.

Appearance	No	Yes	Describe and specify location:
a) Discoloration around face/nose/mouth			
b) Secretions (foam, froth)			
c) Skin discoloration (livor mortis)			
d) Pressure marks (pale, blanching)			
e) Rash or petechiae (small, red blood spots on skin, membranes or eyes)			
f) Marks on body (scratch on nose)			
g) Other			
h) Unknown			

7 How did the infant feel when found?

Sweaty	Warm to touch	Cool to touch	Rigid, stiff	Limp, flexible	Unknown	Other - specify

8 Did you administer resuscitative efforts? If Yes - check all that were done below, If No - Skip to No. 13 on next page.

CPR	IV/IO Access	Gastric Tube	Infant immobilized	Medications	Intubation	Electric shock

Other - Specify:

--

9 List all emergency medications given to the infant:

Name of Medication	Dose	Route	Military Time
1.			:
2.			:
3.			:
4.			:
5.			:

Continued on the next page ►

10 Describe the nature and duration of resuscitation efforts and treatments.

--

11 Describe any injuries sustained by infant during resuscitative efforts (if any):

--

12 At what date and approximate time were the resuscitative efforts terminated?

Not terminated by EMS	Month	Day	Year	Military Time
				:

13 What was the name of the authorizing medical control physician who pronounced death?

Last name	First name	Agency

14 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	Name of person who received the infant

15 Describe the reaction of the caregiver(s) to the infant's death:

--

16 Additional comments from the EMS personnel: *(Describe concerns with scene or what happened)*

--

Investigator's Notes

EMS Run Report/Sheet

911 Tape

Indicate the task(s) performed

--	--

--

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 On what day and at what approximate time did the infant arrive at the hospital?

Month	Day	Year	Military Time
			:

2 Hospital Information:

Hospital Name:	Address:

3 Name of physician responsible for treatment at hospital.

Name:	Phone:

4 Name physician who signed the death certificate.

Name:	Phone:

5 What was the level of consciousness upon arrival at the hospital?

☐ Breathing	☐ Not breathing	☐ Responsive	☐ Unresponsive	☐ Dead
------------------------------------	--	-------------------------------------	---------------------------------------	-------------------------------

What did the infant look like upon arrival at the hospital? (Check all that apply)

Appearance	No	Yes	Describe and specify location:
a) Discolorations			
b) Secretions			
c) Livor mortis			
d) Pale areas around nose or mouth			
e) Retinal hemorrhages			
f) Cutaneous petechiae			
g) Bruising or other injury			
h) Suspicion of inflicted trauma			
i) Malnourished			
j) Other			

6 How did the infant feel upon arrival at the hospital?

☐ Sweaty	☐ Warm to touch	☐ Cool to touch	☐ Rigid, stiff	☐ Limp, flexible	☐ Unknown
---------------------------------	--	--	---------------------------------------	---	----------------------------------

Other - Specify:

7 List all treatments and procedures (T&P) administered to the infant at the hospital:

Treatment or Procedure	Approx. Time	Outcome
1.	:	
2.	:	
3.	:	
4.	:	

8 Hospital staff's comments regarding family's reaction to infant's death.

--

Investigator's Notes

Indicate the task(s) performed	Obtain medical records or code sheet	Secure evidence and release infant's property

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name

First Name

Middle

Case Number

1 Indicate information source (Check appropriate box)☐

Biological Mother/Father

☐

Grandmother/Father

☐

Adoptive or Foster Parents

☐

Physician

☐

Health Records

☐

Other (specify):

2 Has the infant ever received immunizations or shots?

Yes No - (stop)

☐☐Please list all of the immunizations the infant has ever been given **or attach record.**

Immunization:	Month	Day	Year	Comments/Reactions:
Hepatitis B #1				
Hepatitis B #2				
Hepatitis B #3				
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)				
Measles, Mumps, Rubella (MMR)				
Varicella (Chicken Pox)				
Pneumococcal				
Influenza (Flu)				
Hepatitis A #1				
Hepatitis A #2				
Other/Specify:				

3 Are the immunizations up to date?

Yes No Unknown

☐☐☐

Section Completed by (name)

Month

Day

Year

Military Time

In person

Telephone

Other

----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Infant's Information

Last Name

First Name

Middle

Case Number

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

(being in the same room, living in/staying in/visiting the infant's primary residence - if more than 3 persons, use additional pages)

	Person 1			Person 2			Person 3		
a) Last name									
b) First name									
c) Maiden name (if applicable)									
d) Relationship to infant									
e) Street									
f) City									
h) DOB	Month	Day	Year	Month	Day	Year	Month	Day	Year
i) Where did contact with the infant occur (ex. house, daycare, playground)									
j) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
k) Approximate time of last contact with the infant (Military Time)									
l) During the week prior to the infant's death, was this person sick? (If "Yes", explain the circumstances below)	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
m) For persons biologically related to the infant (d above) are there any known conditions/diseases that run in the family? (down syndrome)	Yes	No	NA	Yes	No	NA	Yes	No	NA
	Explain:			Explain:			Explain:		
n) Has this person experienced the death of any of their own children or of any other children while in their care?	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
l) Child's name									
II) Relationship to caregiver									
III) Date of death	Month	Day	Year	Month	Day	Year	Month	Day	Year
IV) Child's age at death (years or months if <2 years)									
V) Cause of death									
VI) Place of death (City/State)									

2 Did the infant visit a location with large numbers of people within the last 24 hours?
3 Are there any factors, circumstances, or environmental concerns?

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

No Yes If yes - please describe

Continued on the next page ►

E - INFANT EXPOSURE HISTORY

Did the infant visit a daycare in the 24 hours prior to the death?

--	--

If yes - specify

--	--	--

□

	Child 1			Child 2			Child 3		
a) First name of child									
b) Last name of child									
c) Date of birth	Month	Day	Year	Month	Day	Year	Month	Day	Year
d) Where did contact with the infant occur (<i>ex. house, daycare, play-ground</i>)									
e) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
f) Approximate time of last contact with the infant									
g) During the week prior to the infant's death, was this person sick? (<i>If "Yes", explain the circumstances</i>)	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name

First Name

Middle

Case Number

1 For each informant interviewed, please obtain the following information:**Informant 1**

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 2

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 3

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 4

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 5

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 6

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

F - INFORMANT CONTACT

Section Completed by (name)

Month

Day

Year

Military Time

In person

Telephone

Other

Infant's Information

Last Name

First Name

Middle

Case Number

Information about the Law Enforcement officer:

Last name

Middle name

Last name

Phone number

Agency

Month

Day

Year

Military Time

Date and time dispatched:

:

Who called?

Relationship (ex. aunt):

1 What date and time did you arrive?

Month

Day

Year

Military Time

:

2 What did the infant look like when you arrived at the scene?

Appearance

No

Yes

Describe and specify location:

a) Discoloration around face/nose/mouth			
b) Secretions (<i>foam, froth</i>)			
c) Skin discoloration (<i>livor mortis</i>)			
d) Pressure marks (<i>pale, blanching</i>)			
e) Rash or petechiae (<i>small, red blood spots on skin, membranes or eyes</i>)			
f) Marks on body (<i>scratch on nose</i>)			
g) Other			
h) Unknown			

3 How did the infant feel when found?

☐

Sweaty

☐

Warm to touch

☐

Cool to touch

☐

Rigid, stiff

☐

Limp, flexible

☐

Unknown

Other - Specify:

4 How would you describe the surface on which the infant was placed?

Condition of surface (check all that apply):

☐

Soft

☐

Firm

☐

Lumpy

☐

Concave

☐

Stained

☐

Wet

5 Describe condition: (check all that apply):

☐

Broken

☐

Worn

☐

Repaired

☐

Clean

☐

Dirty

6 Describe what the scene looked like upon arrival:

7 Describe what law enforcement did at the scene:

8 Describe the person's reactions to the infant's death:

Individual

No

Yes

Specify:

Mother			
Father			
Placer			
Finder			
Last Known Alive			
Other			

Continued on the next page ►

8 Are there any known prior contacts with law enforcement?

Individual	No	Yes	Reason for contact	Outcome
Mother				
Father				
Placer				
Finder				
Last Known Alive				
Other				

9 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:
(Indicate facility name and name of person who received the infant)

10 Have there been any contacts/complaints to social services regarding this family and other siblings in the home?

Yes No - (stop)

--	--

11 Total number of contacts with social services:

12 List up to two most recent contacts with social services.

Date contacted:
 Month Day Year

Caseworker name:

Agency name:

Reason for contact:

Outcome:

Comments:

Date contacted:
 Month Day Year

Caseworker name:

Agency name:

Reason for contact:

Outcome:

Comments:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other

Infant's Information

Last Name	First Name	Middle	Case Number

8 Describe all items recovered from the site of the incident or death scene:

Item	Evidence No.	Origin	Description	Disposition	Name of person collecting
1) Baby bottles					
2) Pacifier					
3) Formula					
4) Bedding					
5) Infant's last diaper					
6) Clothing					
7) Apnea monitor					
8) Infant sleep surface					
9) Medicines (include home remedies)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					
27)					
28)					
29)					
30)					

H - MATERIALS COLLECTION LOG

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name

First Name

Middle

Case Number

1 Information about the person who was the first non-professional responder to the infant:

Last name

Middle name

Last name

Phone number

Relationship to infant

☐

Male

☐

Female

Age:

Date of Birth:

2 What led you to respond?**3 When the infant was found, was s/he:**☐

breathing

☐

not breathing

☐

unresponsive

If not breathing, did you witness the infant stop breathing?

☐

yes

☐

no

4 Describe infant's appearance when found.

Appearance

No

Yes

Describe and specify location:

a) Discoloration around face/nose/mouth	☐	☐	
b) Secretions (<i>foam, froth</i>)	☐	☐	
c) Skin discoloration (<i>livor mortis</i>)	☐	☐	
d) Pressure marks (<i>pale, blanching</i>)	☐	☐	
e) Rash or petechiae (<i>small, red blood spots on skin, membranes or eyes</i>)	☐	☐	
f) Marks on body (<i>scratch on nose</i>)	☐	☐	
g) Other	☐	☐	
h) Unknown	☐	☐	

5 How did the infant feel when found?☐

Sweaty

☐

Warm to touch

☐

Cool to touch

☐

Rigid, stiff

☐

Limp, flexible

☐

Unknown

Other - Specify:

6 What date and time were the first resuscitative efforts given?

Month

Day

Year

Military Time

7 Where were resuscitative efforts conducted?**8 Describe what you did as part of the resuscitative efforts (ex. pushed on chest and breathed into mouth and nose):****9 Have you ever received any First Aid and/or CPR training?**☐

No

☐

Yes

When:

Describe:

I - NONPROFESSIONAL RESPONDER INTERVIEW

Section Completed by (name)

Month

Day

Year

Military Time

In person

Telephone

Other

Infant's Information

Last Name

First Name

Middle

Case Number

Indicate information source
☐ Biological Mother/Father
 ☐ Grandmother/Father
 ☐ Adoptive or Foster Parents
 ☐ Physician
 ☐ Health Records
Other - Specify: **1 Information about the infant's mother:**
 First name: Middle name: Last name:
 DOB: SS#: Maiden name:
*Current address:*Street: City: State: Zip: How long has the mother been a resident of this state? Years: Months: Has the mother ever lived in a state other than this one? ☐ No ☐ YesList all previous states: **2 Information about the infant's biological mother:**
 First name: Middle name: Last name:
 DOB: SS#: Maiden name:
*Current address:*Street: City: State: Zip: How long has the mother been a resident of this state? Years: Months: Has the mother ever lived in a state other than this one? ☐ No ☐ YesList all previous states: **3 Information about the infant's father:**
 First name: Middle name: Last name:
 DOB: SS#:
*Current address:*Street: City: State: Zip: How long has the father been a resident of this state? Years: Months: Has the father ever lived in a state other than this one? ☐ No ☐ YesList all previous states: **4 Information about the infant's biological father:**
 First name: Middle name: Last name:
 DOB: SS#:
*Current address:*Street: City: State: Zip: How long has the father been a resident of this state? Years: Months: Has the father ever lived in a state other than this one? ☐ No ☐ YesList all previous states:

Continued on the next page ►

5 Information about the infant's other primary caregivers: (ex. babysitter while parents are at work)

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

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

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

6 Information about the infant's other primary caregivers:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

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

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

7 Information about the infant's other primary caregivers:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

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

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other

Infant's Information

Last Name

First Name

Middle

Case Number

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

1 Address of primary residence:

Street: City: State: Zip:

2 How many people live at the infant's primary residence?

Number of adults (18 years or older): Number of children (under 18 years old):

3 What type of building is the primary residence?

☐ Apartment ☐ Multifamily home ☐ Institution (ex. shelter)
☐ Single family house ☐ Mobile home ☐ Other Specify:

4 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 ☐ Electric (radiant) ceiling heat ☐ Window fan ☐ Unknown
☐ Other - specify:

5 The infant's primary residence has: (Check all that apply)

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

6 What was the source of drinking water at the infant's primary residence? (Check all that apply)

☐ Public/Municipal water source ☐ Bottled water
☐ Well ☐ Unknown
☐ Other - specify:

7 What is the general appearance of the infant's primary residence? (ex. cleanliness, hazards, overcrowding, etc.)

Section Completed by (name)

Month

Day

Year

Military Time

In person

Telephone

Other

A large rectangular area filled with a fine grid of small squares, typical of graph paper. The grid is composed of 30 columns and 40 rows of squares. This area is intended for a drawing or detailed notes related to the primary residence investigation.

Infant's Information

last name	first name	middle	case number

1 Draw the following on the scene diagram. (For people and objects, give the name, show location, show position)

- | | | |
|--|--|-------------------------------------|
| a) Room dimensions and North Direction | d) Those sharing the same sleeping surface | g) Items in contact with the infant |
| b) Crib, bed or sleep surface | e) Furniture and other objects in room | |
| c) Infant's position when found | f) Heating and cooling sources | |

L - SCENE DIAGRAM

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. Half of these sudden, unexplained infant deaths (SUIDs) are due to sudden infant death syndrome (SIDS), the leading cause of SUIDs and of deaths among infants aged 1 month to 1 year. Only sudden infant deaths that remain unexplained after a thorough examination of the death scene, a review of the clinical history, and an autopsy should be classified as SIDS. However, since 1999, some deaths due to SIDS are classified as due to an unknown cause or to accidental suffocation. Inaccurate or inconsistent classification of causes of infant deaths impedes prevention efforts because researchers cannot monitor national trends, determine risk factors, or evaluate prevention programs.

To standardize investigations of, and reports on, the causes of sudden infant deaths, the Centers for Disease Control and Prevention (CDC) collaborated with organizations who investigate infant deaths to 1) revise the 1996 Sudden, Unexplained Infant Death Investigation Reporting Form and 2) develop a training curriculum and materials for investigators of infant deaths. We are now disseminating the reporting form and conducting train-the-trainer classes throughout the United States.

See www.cdc.gov/SIDS.

The New SUIDI Reporting Form is Important for Several Reasons:

- It contains 25 questions that medical examiners must ask before an autopsy is done.
- It guides investigators through the steps involved in an investigation.
- It allows investigators to document their findings easily and consistently.
- It improves classification of SIDS and other SUIDs by standardizing data collection.
- It produces information that researchers can use to recognize new health threats and risk factors for infant death so that future deaths can be prevented.

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Improvements in the SUIDI Reporting Form:

- It now contains only questions to which answers will 1) establish cause and manner of death and 2) support investigators' findings in court.
- It contains new questions about recently recognized risk factors.
- Answers to the questions can be checked off quickly, which allows for easy, consistent data collection.
- The questions are in a sequence that works well for infant-death investigations.
- The form is divided into sections, with each section being the responsibility of a particular member of the death investigation team.
- Supplemental forms for collecting information about contacts and evidence are available for jurisdictions that do not have their own.

SUIDI Reporting Form: a Guide for Investigators

The SUIDI reporting form is a guide for novice and veteran investigators of infant deaths. The form is designed to ensure that all information is collected in a consistent, sensitive manner. Training materials on how to complete the form are available.

How to use the SUIDI Reporting Form

The form is designed as a questionnaire, that is, you can read it to the person you are interviewing. Most questions can be answered by placing an "X" in the corresponding checkbox or filling in the blank provided. The 8 page form is divided into eight sections.

Investigation Data

This section is filled out first by the person interviewing the witness.

- **Military time.** Time based on a 24 hour clock which begins each day at midnight (e.g., midnight = 0000, 2 p.m. = 1400)
- **SS#.** Social security number.
- **DOB.** Date of birth.
- **Primary residence.** Place where the infant lived at time of their death.
- **Incident address.** Place where the infant died or where the final injury occurred.
- **Witness.** Person who knows the circumstances surrounding the infant's death. They may be the person who 1.) last placed the infant in or near the area where he was found not breathing or breathing but in distress, 2.) last observed the infant alive, or 3.) found the infant not breathing or breathing but in distress.

Witness Interview

This section is filled out by the person (e.g., coroner, death scene investigator, law enforcement or medical examiner) interviewing the witness.

- **Usual caregiver.** Person who took care of the infant more than 50% of the time.
- **Placed** Put in or near the area where he was found not breathing or breathing but in distress (e.g., placed in a crib).
- **Last known alive.** Observed to be alive (e.g., parent heard the infant cry).
- **Found.** Discovered not breathing or breathing but in distress (e.g., mom found infant not breathing).
- **Wedging.** Compression of the infant's body or face into a narrow space resulting in interference with chest wall movements and normal breathing (e.g., infant found wedged between mattress and bed frame).

Infant Medical History

This section is filled out by the person investigating the infant death. This information may be obtained from the infant's healthcare provider, medical record or caregiver.

- **Birth defect.** A physical or functional abnormality that the infant had at birth (e.g., spina bifida, congenital heart defect, Down's syndrome).

Pregnancy History

This section is filled out by the person interviewing the biological mother or someone who knows her and her history well (e.g., healthcare provider, medical record or maternal grandmother).

- **Biological mother.** Woman who gave birth to the dead infant.

Incident Scene Investigation

This section is filled out by the person investigating the infant death.

Scene Diagrams

This section is filled out by the person investigating the infant death. It includes a scene diagram and a body diagram. The investigator indicates the following on the scene diagram:

- North direction
- Windows and doors
- Wall lengths and ceiling height
- Location of furniture including infant's bed or sleep surface
- Infant body location when found
- Position of other persons or animals found near infant
- Location of heating and cooling devices
- Location of other objects in room

The Investigator Indicates the Following on the Body Diagram:

- Discoloration around face/nose/mouth
- Secretions (drainage or discharge from anywhere on body)
- Skin discoloration (livor mortis)
- Pressure mark areas (pale areas, blanching)
- Rash or petechiae (small, red blood spots on skin, membranes or in eyes)
- Marks on body (scratch or bruises)
- Location of medical devices
- Body temperature

Summary for Pathologist

This section summarizes all the information collected during the witness interview and investigation at the incident or death scene. This section is completed last by the person investigating the infant death.

- **Asphyxia.** Condition of severely deficient supply of oxygen to the body that can rapidly lead to unconsciousness and death (e.g. compression of infant's chest due to wedging or a person lying on the infant).
- **Overlying.** Situation where someone or something is placed on or over the infant.
- **Hyperthermia.** Condition where core body temperature is abnormally high (e.g., above 40°C (104°F) is considered life-threatening).
- **Hypothermia.** Life-threatening condition where core body temperature falls below 35°C (95°F).



SUIDI

Reporting Form

INVESTIGATION DATA

Infant's Last Name	Infant's First Name	Middle Name	Case Number
Sex:	Date of Birth:	Age:	SS#:
Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Isl. ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other			
Infant's Primary Residence:			
Address:	City:	County:	State: Zip:
Incident Address:	City:	County:	State: Zip:

Contact Information for Witness:

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

Last: First: M.: SS#:

Address: City: State: Zip:

Work Address: City: State: Zip:

Home Phone: Work Phone: Date of Birth:

WITNESS INTERVIEW

- Are you the usual caregiver?**
☐ No ☐ Yes
- Tell me what happened:**
- Did you notice anything unusual or different about the infant in the last 24 hrs?**
☐ No ☐ Yes Specify:
- Did the infant experience any falls or injury within the last 72 hrs?**
☐ No ☐ Yes Specify:
- When was the infant LAST PLACED?**
Date: Military Time: : Location (room):
- When was the infant LAST KNOWN ALIVE(LKA)?**
Date: Military Time: : Location (room):
- When was the infant FOUND?**
Date: Military Time: : Location (room):
- Explain how you knew the infant was still alive.**
- Where was the infant - (P)laced, (L)ast known alive, (F)ound (write P, L, or F in front of appropriate response)?**

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

WITNESS INTERVIEW (cont.)

10 In what position was the infant LAST PLACED? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the usual position?

11 In what position was the infant LKA? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the usual position?

12 In what position was the infant FOUND? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No What was the 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 - 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			Other, specify:		
Rubber or plastic sheet					
Other, specify:					

22 Which of the following devices were operating in the infant's room?
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ Other -

23 In was the temperature in the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other -

24 Which of the following items were near the infant's face, nose, or mouth?
☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other -

25 Which of the following items were within the infant's reach?
☐ Blankets ☐ Toys ☐ Pillows ☐ Pacifier ☐ Nothing ☐ Other -

26 Was anyone sleeping with the infant? ☐ No ☐ Yes

Name of individual sleeping with infant	Age	Height	Weight	Location in relation to infant	Impairment (intoxication, tired)

27 Was there evidence of wedging? ☐ No ☐ Yes - Describe:

28 When the infant was found, was s/he: ☐ Breathing ☐ Not Breathing
If not breathing, did you witness the infant stop breathing? ☐ No ☐ Yes

WITNESS INTERVIEW (cont.)

29 What had led you to check on the infant?

30 Describe the infant's appearance when found.

Appearance	Unknown	No	Yes	Describe and specify location
a) Discoloration around face/nose/mouth				
b) Secretions (foam, froth)				
c) Skin discoloration (livor mortis)				
d) Pressure marks (pale areas, blanching)				
e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)				
f) Marks on body (scratches or bruises)				
g) Other				

31 What did the infant feel like when found? (Check all that apply.)

☐ Sweaty
 ☐ Warm to touch
 ☐ Cool to touch
 ☐ Limp, flexible
 ☐ Rigid, stiff
 ☐ Unknown
☐ Other - specify:

32 Did anyone else other than EMS try to resuscitate the infant? ☐ No ☐ Yes

Who? Date: Military time: :

33 Please describe what was done as part of resuscitation:

34 Has the parent/caregiver ever had a child die suddenly and unexpectedly? ☐ No ☐ Yes

Explain:

INFANT MEDICAL HISTORY

1 Source of medical information: ☐ Doctor ☐ Other healthcare provider ☐ Medical record ☐ Family

☐ Mother/primary caregiver ☐ Other:

2 In the 72 hours prior to death, did the infant have:

Condition	Unknown	No	Yes	Condition	Unknown	No	Yes
a) Fever				h) Apnea (stopped breathing)			
b) Diarrhea				i) Decrease in appetite			
c) Excessive sweating				j) Cyanosis (turned blue/gray)			
d) Stool changes				k) Vomiting			
e) Lethargy or sleeping more than usual				l) Seizures or convulsions			
f) Difficulty breathing				m) Choking			
g) Fussiness or excessive crying				n) Other, specify:			

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

☐ No ☐ Yes - describe:

4 In the 72 hours prior to the infant's death, was the infant given any vaccinations or medications?

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

Name of vaccination or medication	Dose last given	Date given			Approx. time (Military Time)	Reason given/comments:
		Month	Day	Year		
1.						
2.						
3.						
4.						

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

Medical history	Unknown	No	Yes	Describe
a) Allergies (<i>food, medication, or other</i>)				
b) Abnormal growth or weight gain/loss				
c) Apnea (<i>stopped breathing</i>)				
d) Cyanosis (<i>turned blue/gray</i>)				
e) Seizures or convulsions				
f) Cardiac (<i>heart</i>) abnormalities				

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 healthcare provider:

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

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

8 Birth hospital name: Discharge date:

Street address:

City: State: Zip:

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? ☐ Late - how many weeks?

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

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadrupelet or higher gestation

13 Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen) ☐ Yes ☐ No

Describe:

14 Are there any alerts to the pathologist? (previous infant deaths in family, newborn screen results) ☐ Yes ☐ No

Specify:

INFANT DIETARY HISTORY

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

Date: 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)?

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

5 Was a new food introduced in the 24 hours prior to his/her death? ☐ No ☐ Yes

If yes, describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle? ☐ Yes ☐ No - if no, skip to question **9** below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds) ☐ No ☐ Yes

If yes, what object was used to prop the bottle?

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

9 Did the death occur during? ☐ Breastfeeding ☐ 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

If yes, - describe:

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name: Last name:
 Middle name: Maiden name:
 Birth date: SS#:

Street address: City: State: Zip:

How long has the birth mother been at this address? Years: Months:

Previous Address:

2 At how many weeks or months did the birth mother begin prenatal care? ☐ No prenatal care ☐ Unknown

Weeks: Months:

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

Physician/provider: Hospital/clinic: Phone:

Street address: City: State: Zip:

PREGNANCY HISTORY (cont.)

4 During her pregnancy with the infant, did the mother have any complications? ☐ No ☐ Yes
(ex. high blood pressure, bleeding, gestational diabetes)
Specify: _____

5 Was the birth 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		Unknown	No	Yes	Daily
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		Unknown	No	Yes	Daily
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? ☐ No ☐ Yes

3 Is the site of the incident or death scene a daycare or other childcare setting? ☐ Yes ☐ No - If no, skip to question 8

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

5 How many adults (age 18 and over) were supervising the child(ren)? _____

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	☐ Electric (radiant) ceiling heat	☐ Window fan	☐ Unknown

☐ Other - specify: _____

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 ☐ Bottled water ☐ Well ☐ Unknown ☐ Other - Specify: _____

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

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

☐ Other - specify: _____

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

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

Military time

Law enforcement at scene:

:

DSI at scene:

:

Infant at hospital:

:

Investigator's Notes

1 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	

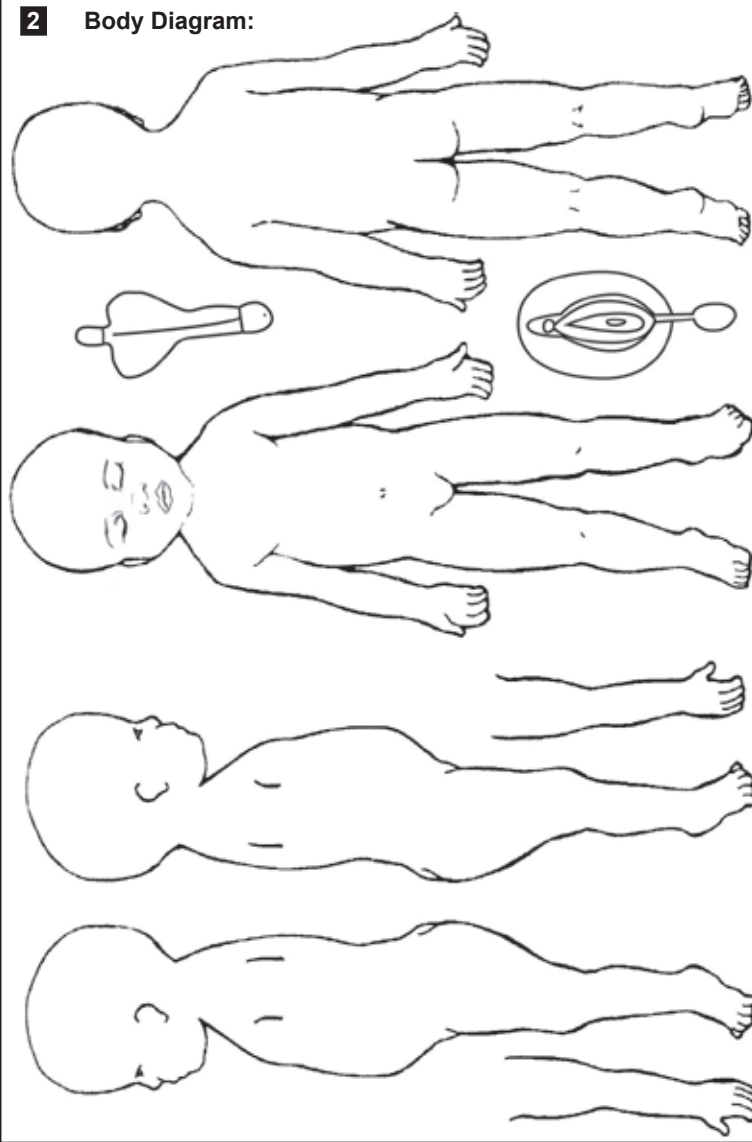
- 2** If more than one person was interviewed, does the information differ? ☐ No ☐ Yes

If 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

1 Investigator information Name: Agency: Phone:

Date Military time

Investigated: :

Pronounced dead: :

2 Infant's information: Last: First: M: Case #:

Sex: ☐ Male ☐ Female Date of Birth: Age:

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 sleep surface with adults, children, or pets
☐	☐	Change in sleep 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 sleep condition (ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)
☐	☐	Diet (e.g., solids introduced, 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)
☐	☐	Prior sibling deaths
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissue or organ donation
☐	☐	Objection to autopsy
☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma (injury), poisoning, or intoxication
☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

Infant History

Family Info

Exam

Investigator Insight

Pathologist

Any "Yes" answers above should be explained in detail (description of circumstances):

2 Pathologist information Name:

Agency: Phone: Fax:



Common Medications



Generic Name	Trade Name	Commonly Prescribed For...
Acetaminophen	Tylenol	Pain
Albuterol	Proventil	Asthma, bronchitis, other breathing disorder
Alendronate	Fosamax	Osteoporosis
Allopurinol	Zyloprim	Lowers uric acid; treats gout and some kidney stones
Alprazolam	Xanax	Benzodiazepine: Anxiety
Amlodipine	Norvasc	Hypertension; chest pain (angina)
Amoxicillin	Amoxil, Augmentin	Antibiotic
Amphetamine & Dextroamphetamine	Adderall	ADHD
Aripiprazole	Abilify	Schizophrenia/ bi-polar disorder
Atenolol	Tenormin	Hypertension; angina
Atomoxetine	Strattera	ADHD
Atorvastatin	Lipitor	Lowers cholesterol and triglyceride levels
Azithromycin	Z-Pak, Zithromax	Antibiotic
Bupropion	Wellbutrin	Depression; also aids in smoking cessation
Carvedilol	Coreg	Hypertension; CHF
Celecoxib	Celebrex	NSAID; common for rheumatoid arthritis
Ciprofloxacin	Cipro	Antibiotic
Citalopram	Celexa	Depression
Clonazepam	Klonopin	Panic attacks/ anxiety/ seizures
Clonidine	Plavix	Clot prevention
Clotrimazole	Lotrisone	Antifungal
Cyclobenzaprine	Flexeril	Muscle relaxant
Dextromethylphenidate	Focalin	ADHD
Diazepam	Valium	Anxiety
Digoxin	Lanoxin	Atrial fibrillation
DivalProEx	Depakote	Seizures/ mood disorders/ migraines
Donepezil	Aricept	Alzheimer's Disease
Enalapril	Vasotec	Hypertension/ CHF
Escitalopram	Lexapro	Depression/ anxiety
Esomeprazole	Nexium	GERD
Eszopiclone	Lunesta	Sleep aid
Fexofenadine	Allegra	Allergies
Finasteride	Proscar	Benign Prostatic Hyperplasia (BPH)
Fluconazole	Diflucan	Antifungal
Fluoxetine	Prozac	Depression/ mood disorders
Furosemide	Lasix	Hypertension/ CHF/ edema
Gabapentin	Neurotin	Seizures/ shingles
Glimepiride	Amaryl	Diabetes Mellitus
Hydrochlorothiazide	Hydrodiuril	Hypertension/ CHF/ edema
Hydrocodone & acetaminop.	Vicodin	Pain

Ipratropium Bromide	Atrovent	Bronchial spasms
Ipratropium Bromide & Albuterol	Combivent	Bronchial spasms
Lansoprazole	Prevacid	GERD
Levothyroxine	Synthroid	Hypothyroidism
Lisdexamfetamine	Vyvanse	ADHD
Lisinopril	Zestril	Hypertension/ CHF
Lorazepam	Ativan	Anxiety
Losartan	Cozaar	Hypertension
Meloxicam	Mobid	Arthritis pain relief
Memantine	Namenda	Alzheimer's Disease
Metformin	Glucophage	Diabetes Mellitus
Metoprolol	Lopressor	Hypertension
Metoprolol XL	Toprol	Hypertension
Montelukast	Singulair	Asthma/ allergies
Naproxen	Aleve/ Naprosyn	Pain
Nifedipine	Procardia	Hypertension/ angina
Nitrofurantoin	Macrobid	UTI
Olanzapine	Zyprexa	Schizophrenia/ bi-polar disorder
Omeprazole	Prilosec	GERD
Oxycodone & acetaminophen	Percocet	Pain
Pantoprazole	Protonix	GERD
Paroxetine	Paxil	Anxiety/ depression/ OCD
Phenytoin	Dilantin	Seizures
Pravastatin	Pravachol	High cholesterol and triglycerides
Propranolol	Inderal	Hypertension/ CHF
Quetiapine	Seroquel	Schizophrenia/ bi-polar disorder/ depression
Quinapril	Accupril	Hypertension/ CHF
Ramipril	Altace	Hypertension/ CHF
Ranitidine	Zantac	GERD
Risperidone	Risperdal	Schizophrenia/ bi-polar disorder
Sertraline	Zoloft	Depression/ anxiety
Sildenafil	Viagra	Erectile dysfunction
Sumatriptan	Imitrex	Migraines
Tamsulosin	Flomax	BPH
Tiotropium Bromide	Spiriva	Bronchial spasms
Topiramate	Topamax	Seizures/ migraines
Tramadol	Ultram	Pain
Trazodone	Desyrel	Depression/ anxiety/ sleep disorder
Valacyclovir	Valtrex	Herpes/ shingles
Vardenafil	Levitra	Erectile dysfunction
Varenicline	Chantix	Smoking cessation
Venlafaxine	Effexor	Depression/ anxiety
Zolpidem	Ambien	Sleep aid

Note:

- Medications ending with **-lol** are beta-blockers, and are prescribed for hypertension, CHF, and management of cardiac arrhythmias. They're sometimes used to treat migraines.
- Medications ending with **-statin** are used to reduce cholesterol and triglyceride levels.

Medication Cheat Sheet

Narcotics

Codeine – MethyImorphine

Fentanyl – Duragesic

Demerol – Meperidine

Morphine – MS Contin, Roxanol, Astramorph, Avinza, Kadian

Oxycodone – Oxycontin, Percocet, Percodan

Tramadol – Ultram (some people do not consider Tramadol a narcotic)

Hydrocodone – Vicodin, Lortab, Norco

Hydromorphone – Dihydromorphinone, Dilaudid

Methadone – Dolophine, Methadose

Antagonist of narcotic – Narcan

Anticoagulants

CHEW PPL, end in “in” usually

Coumadin, Heparin, Eliquis, Warfarin, Plavix, Pradaxa, Lovenox

These help with blood clots

Beta Blockers

Usually end in “lol”

Propranolol, Metoprolol, Atenolol, Bisoprolol

These reduce BP, for heart failure/abnormal rhythm, angina (chest pain/poor blood flow)

Benzodiazepines

Usually end in “lam” “pam”, outlier is Ativan

Diazepam (Valium), Alprazolam (Xanax), Clonazepam (Klonopin), Lorazepam (Ativan), Midazolam

These are psychoactive drugs for anxiety, insomnia, seizures, alcohol withdrawal

Hyperlipidemia Drugs

Usually end in “or” “statin”, outlier is Niacin

Lovastatin, Simvastatin, Pravastatin, Lipitor, Mevacor, Crestor

These are for high lipids, cholesterol

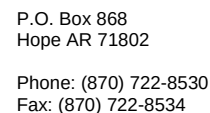
SSRI: Selective Serotonin Reuptake Inhibitors

Usually end in “ine”, outliers are Welbutrin/Bupropion, Cymbalta, Citalopram, Zoloft, Celexa, Prozac, Paxil, Luvox, Effexor, Remeron, Escitalopram

Amitriptyline, Trimipramine, Clomipramine, Fluoxetine (Prozac), Fluvoxamine, Paroxetine (Paxil)

Sertraline (Zoloft), Desipramine, Protriptyline

These are for depression, anxiety, OCD, personality disorders and sometimes narcolepsy,





ARKANSAS STATE CRIME LABORATORY EVIDENCE SUBMISSION FORM

ASCL Case #

All fields required except where noted

www.arkansas.gov/crimelab

Agency Case #

Evidence will be analyzed using a priority based system. List the priority of your evidence for analysis (1= highest)

Evidence #	Evidence Description	Physical Evidence/DNA Requests: 1. List where item was collected 2. List who the item belongs to (if known)	Requested Service (refer to codes below)
1			
2			
3			
4			
5			

Type of Analysis Requested:

Submitting Officer (print):

Signature

Date

Requested Service Codes:

DE: Digital Evidence

DA: Drug Analysis

FA: Firearms / Tool Marks / NIBIN

IL: Illicit Laboratories

LP: Latent Prints

PE/DNA: Physical Evidence / DNA

TOX: Toxicology

ARKANSAS STATE CRIME LABORATORY

BODY SUBMISSION FORM

P.O. Box 8500
3 Natural Resources Drive
Little Rock, Arkansas 72215

PLEASE COMPLETELY FILL IN FORM

Medical Examiner's Office
Phone: (501) 227-5936
Fax: (501) 221-1653

PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES THE DEATH. IF NONE APPLY, PLEASE CALL THE ME'S OFFICE BEFORE COMPLETING THIS FORM.					
☐ CRIMINAL VIOLENCE	☐ DEATHS IN CUSTODY (NON-NATURAL)	☐ INTOXICATION	☐ SKELETONIZED REMAINS		
☐ INFANT/CHILD UNEXPECTED	☐ ACUTE WORKPLACE INJURY	☐ SUSPECTED DROWNING	☐ CHARRED BODIES		
☐ POLICE ACTION	☐ ELECTROCUTION	☐ UNIDENTIFIED BODIES	☐ VEHICULAR (WHEN NECESSARY FOR COD)		
NAME OF DECEASED:			POSITIVE ID BY:		
AGE:	RACE:	SEX:	DATE OF BIRTH:	SOCIAL SECURITY #:	
MARITAL STATUS:	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN	NEXT OF KIN:		RELATIONSHIP:	
Infectious Diseases: HIV? ☐ Y ☐ N ☐ Unknown HEPATITIS? ☐ Y ☐ N ☐ Unknown TUBERCULOSIS? ☐ Y ☐ N ☐ Unknown					
DATE/TIME LAST SEEN ALIVE:		BY WHOM:		RELATIONSHIP:	
PLACE OF INCIDENT (Address):					
CITY:			COUNTY:		
INCIDENT OR FOUND ON DATE:			TIME: ☐ AM ☐ PM		
POSITION FOUND:		FOUND BY:		LOCATION FOUND (e.g., bedroom):	
DATE/TIME PRONOUNCED DEAD:		☐ AM ☐ PM	BY WHOM:		TITLE:
PLACE OF DEATH:		SAME AS DECEDENT'S ADDRESS? ☐ Y ☐ N		DECEDENT'S ADDRESS:	
INVESTIGATING AGENCY:			PERSON TO CONTACT FOR INVESTIGATIVE INFORMATION:		
ADDRESS:			DIRECT PHONE:		
CITY: STATE: ZIP:			EMAIL ADDRESS:		
			AGENCY CASE #:		
CORONER/DEPUTY (Include title):			DIRECT PHONE:		
			EMAIL ADDRESS:		
			AGENCY CASE #:		
LOCATION OF BODY TO BE PICKED UP:					
CONTRACTING FUNERAL HOME:					
IF KNOWN, RIGOR:		BODY TEMP:		AMBIENT TEMP:	
LIVIDITY:					
IF SUSPICIOUS DEATH, STATE REASONS:					
PAST MEDICAL HISTORY, MEDICATIONS, PRIMARY CARE PHYSICIAN:					
SUMMARY OF CIRCUMSTANCES (Use additional paper if necessary):					
NAME OF OFFICER (Print):			TITLE:		SIGNATURE: