

Ohio Department of Health • Sudden Infant Death Program

Infant Death Home Visit Report

Section A: Demographic Information

Infant's name last		first		middle initial		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (DOB) / /	
Date of death / /	Date notified of death / /	Gestational age in weeks	Ethnicity <input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Unknown					
Place of birth (Hospital)			City		State	Birth weight lbs ____ ozs ____ or grams ____		

Section B: Parent Information

Mother's name last				first		middle initial		maiden	Age	Telephone ()	
Address			City			State	ZIP		County		
Father's name last				first		middle initial		Age	Telephone ()		
Address			City			State	ZIP		County		

Section C: Death Information

Place of death -Street address			City		State	ZIP		County			
Who found the infant? Name		Relation			Phone ()		Household information Number of adults Number of children				
Tentative Diagnosis at Pronouncement <input type="checkbox"/> SIDS <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					Final (Death Certificate) diagnosis <input type="checkbox"/> SIDS <input type="checkbox"/> Pending <input type="checkbox"/> Other (specify) _____						
Other SIDS deaths in family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If other SIDS death Name Relation								
Position of infant at discovery <input type="checkbox"/> On stomach, face down <input type="checkbox"/> On stomach, face to side <input type="checkbox"/> On back <input type="checkbox"/> On side <input type="checkbox"/> Unknown					Location of infant when found <input type="checkbox"/> Crib <input type="checkbox"/> Playpen <input type="checkbox"/> Couch <input type="checkbox"/> Floor <input type="checkbox"/> Other Bed <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____						
Illness in the 2 weeks prior to death <input type="checkbox"/> Yes, specify illness _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown					Infant sleeping with others <input type="checkbox"/> Yes, specify whom _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown						
Infant sleeping alone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Second-hand cigarette exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Overheating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

Section D: Home Visit Information

Date of first contact with family / /		Contact type <input type="checkbox"/> Phone <input type="checkbox"/> In person <input type="checkbox"/> Letter <input type="checkbox"/> Other <input type="checkbox"/> Unable to contact				Date of home visit / /		Duration of home visit (in minutes)	
Were any of the following helpful or supportive? Rescue Squad <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Police <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Clergy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Funeral Director <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Coroner/Medical Examiner <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Other (specify) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A									
Did you or anyone else: a. Provide the family with written information about SIDS, other causes of death, or bereavement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown c. Which referrals to community resources were made? <input type="checkbox"/> No referrals made									
					1)		2)		
					3)		4)		

Section E: Contact Information For Person Completing Report

Name		Agency			Telephone ()		Date / /	
Address		City			State	ZIP		County