

Ohio Department of Health • Sudden Infant Death Program

Report of Family Contact

Date Referral Received: _____

Infant's name		Date of birth	Date of death	
Last		First		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	
Mother's Name				
Last		First	Phone	
Address		City	Zip	
Father's Name				
Last		First	Phone	
Address <input type="checkbox"/> Same as Mother		City	Zip	
Other Family				
Last		First	Relationship	
Address <input type="checkbox"/> Same as Mother		City	Zip	
Family Contact Record				
Date	Type of Contact			Next Steps
	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Visit	
	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Visit	
	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Visit	
	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Visit	
Information Provided to Family				
Referrals Made for Family				
Family Notes/Comments (Use back of form if needed)				
Please record the following information only if it is learned through conversation with the family Your role is to assist with bereavement, not to investigate the death.				
Location at time of death <input type="checkbox"/> Crib/bassinet <input type="checkbox"/> Playpen <input type="checkbox"/> Adult Bed <input type="checkbox"/> Couch/Chair <input type="checkbox"/> Infant Seat <input type="checkbox"/> Other _____				
Infant placed to sleep <input type="checkbox"/> On Back <input type="checkbox"/> On Stomach <input type="checkbox"/> On Side <input type="checkbox"/> Other				
Infant sharing sleep surface with <input type="checkbox"/> Adults <input type="checkbox"/> Children <input type="checkbox"/> Blankets <input type="checkbox"/> Pillows <input type="checkbox"/> Other _____				
Report Completed By				
Name			Agency	
Address			City	Zip
Phone		Cell	County	