

Ohio Department of Health

Notification of Infant Death

Infant's Name			Last		First		Middle		Date of Birth		Date of Death		
Gender		Age	Hispanic Ethnicity		Race (Check all that apply)								
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Hawaiian Native / Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____						
County of Death				County of Residence				County of Autopsy					
Father's Name			Last		First		Middle		Area Code and Phone Number			Age	
Residence		Street Address						City		State		Zip	
Mother's Name			Last		First		Middle		Area Code and Phone Number			Age	
Residence		Street Address						City		State		Zip	
<p>The Preliminary diagnosis of this death is:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> SIDS <input type="checkbox"/> Unintentional Injury / Accident <input type="checkbox"/> Asphyxia <input type="checkbox"/> Other Unintentional Injury <input type="checkbox"/> Inflicted Injury / Homicide <input type="checkbox"/> Circumstances dictate that NO contact with the family should be made until final diagnosis </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Undetermined (Natural) <input type="checkbox"/> Undetermined (Not Natural) <input type="checkbox"/> Undiagnosed Disease / Natural <input type="checkbox"/> Other (Please Explain) </td> </tr> </table>												<input type="checkbox"/> SIDS <input type="checkbox"/> Unintentional Injury / Accident <input type="checkbox"/> Asphyxia <input type="checkbox"/> Other Unintentional Injury <input type="checkbox"/> Inflicted Injury / Homicide <input type="checkbox"/> Circumstances dictate that NO contact with the family should be made until final diagnosis	<input type="checkbox"/> Undetermined (Natural) <input type="checkbox"/> Undetermined (Not Natural) <input type="checkbox"/> Undiagnosed Disease / Natural <input type="checkbox"/> Other (Please Explain)
<input type="checkbox"/> SIDS <input type="checkbox"/> Unintentional Injury / Accident <input type="checkbox"/> Asphyxia <input type="checkbox"/> Other Unintentional Injury <input type="checkbox"/> Inflicted Injury / Homicide <input type="checkbox"/> Circumstances dictate that NO contact with the family should be made until final diagnosis	<input type="checkbox"/> Undetermined (Natural) <input type="checkbox"/> Undetermined (Not Natural) <input type="checkbox"/> Undiagnosed Disease / Natural <input type="checkbox"/> Other (Please Explain)												
<p>Form Completed by: _____</p> <p>Area Code and Phone Number: _____</p> <p>County: _____</p>													

Please send this report to:

SID Network of Ohio
 421 Graham Road, Suite H
 Cuyahoga Falls, OH 44221
 Or FAX (330)929-0593

If you have questions regarding this form, please call Leslie Redd at (800)477-7437