DEPARTMENT OF HEALTH AND HUMAN SERVICES
Maternal and Infant Health Branch
Division of Reproductive Health
Centers for Disease Control and Prevention
Atlanta, Georgia 30333

CDC

Sudden Unexplained Infant Death Investigation

SUIDI Reporting Form

INVESTIGATION DATA

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

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

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

Infant's Primary Residence Address:

Address _____ City _____ County _____ State _____ Zip _____

Incident Address:

Address _____ City _____ County _____ State _____ 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 ____/____/____ (Month / Day / Year)

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 _____

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 infant's 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 infant's 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 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 ⇨ 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 **What was the temperature of 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 these people.

Name	Age	Height	Weight	Location in Relation to Infant	Impaired *(intoxicated, 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 infant's appearance when found.**

	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 and when?

Who _____ __ ___/___/_____ ____:____
Month Day Year 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
☐ Mother/primary caregiver ☐ Family ☐ Other: _____

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

	Unknown	No	Yes		Unknown	No	Yes
a) Fever	☐	☐	☐	h) Diarrhea	☐	☐	☐
b) Excessive sweating	☐	☐	☐	i) Stool changes	☐	☐	☐
c) Lethargy or sleeping more than usual	☐	☐	☐	j) Difficulty breathing	☐	☐	☐
d) Fussiness or excessive crying	☐	☐	☐	k) Apnea *(stopped breathing)*	☐	☐	☐
e) Decrease in appetite	☐	☐	☐	l) Cyanosis *(turned blue/gray)*	☐	☐	☐
f) Vomiting	☐	☐	☐	m) Seizures or convulsions	☐	☐	☐
g) Choking	☐	☐	☐	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 infants death, was the infant given any vaccinations or medications?**
(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

☐ No ☐ Yes ⇨ List below:

Name of vaccination or medication	Dose last given	Date given Month Day Year	Approx. time Military Time	Reasons given/ comments:
1. _____	_____	___/___/_____	____:____	_____
2. _____	_____	___/___/_____	____:____	_____
3. _____	_____	___/___/_____	____:____	_____
4. _____	_____	___/___/_____	____:____	_____

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	_____	_____
h) State, ZIP	_____ _____	_____ _____
i) 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 ☐ Twin ☐ 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 _____ Previous Address _____ _____
Years Months 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 birth mother have any complications?**
(ex. high blood pressure, bleeding, gestational diabetes)

☐ No ☐ Yes ⇨ 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 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 old)*

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 paraphenalia
☐ 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: _____:_____ (Military Time) DSI at scene: _____:_____ (Military Time) Infant at hospital: _____:_____ (Military Time)

Investigator's Notes

Indicate the task(s) performed.

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

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.)*

_____

_____

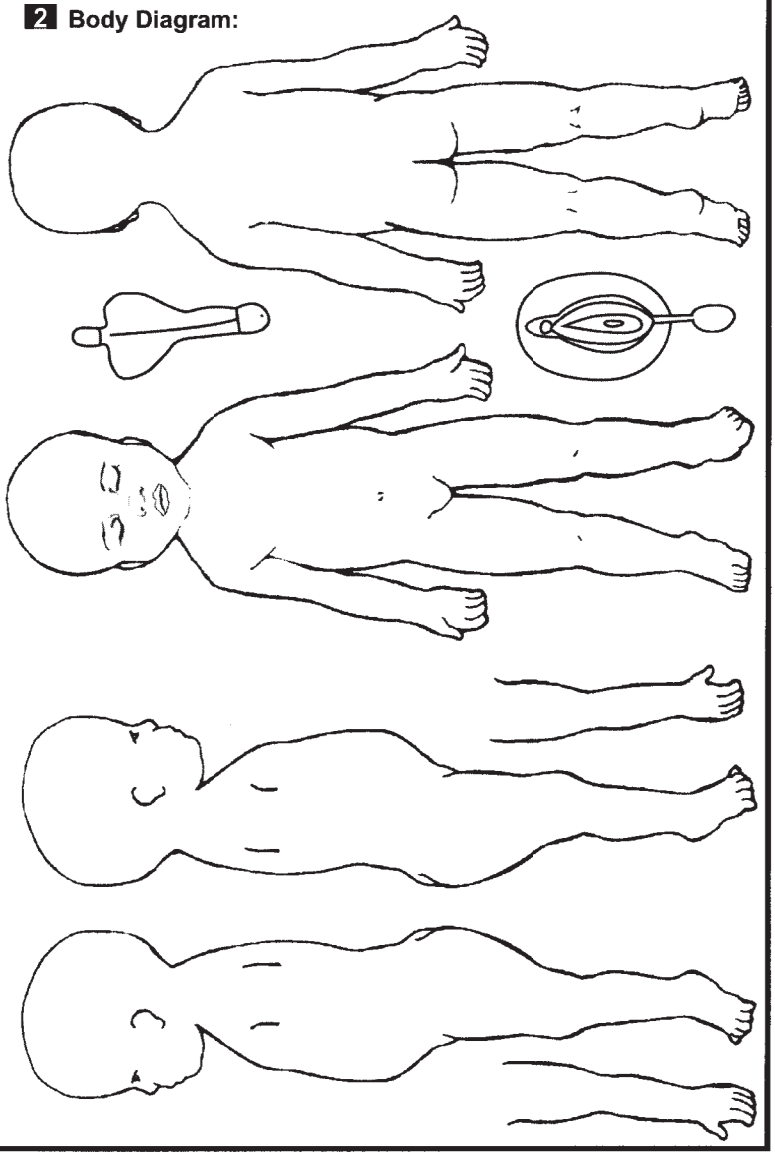
_____

_____

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 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)*

Infant History

☐	☐	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)*

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 (____) _____ - _____