

Ohio Department of Health

Notification of Infant Death

Infant's Name				Date of Birth		Date of Death			
Last		First		Middle					
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"/> Undetermined (Natural) <input type="checkbox"/> Other (Please Explain) _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Undiagnosed Disease / Natural <input type="checkbox"/> Inflicted Injury / Homicide <input type="checkbox"/> Undetermined (Not Natural) <input type="checkbox"/> Circumstances dictate that NO contact with the family should be made until Final Diagnosis </td> </tr> </table>								<input type="checkbox"/> SIDS <input type="checkbox"/> Unintentional Injury / Accident <input type="checkbox"/> Undetermined (Natural) <input type="checkbox"/> Other (Please Explain) _____	<input type="checkbox"/> Undiagnosed Disease / Natural <input type="checkbox"/> Inflicted Injury / Homicide <input type="checkbox"/> Undetermined (Not Natural) <input type="checkbox"/> Circumstances dictate that NO contact with the family should be made until Final Diagnosis
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<p style="text-align: center;">Form Completed by: _____</p> <p style="text-align: center;">Area Code and Phone Number: _____</p> <p style="text-align: center;">County: _____</p>									

Ohio Department of Health

Final Diagnosis of Infant Death

Infant's Name				Date of Birth		Date of Death		
Last		First		Middle				
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		
Parents' Name			Address			City	State	Zip
Final Diagnosis								
Part I. Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Type or print in permanent black ink.								
				Cause of Death		Approximate Interval between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)			A.					
Sequentially list conditions, if any, leading to the immediate cause			B.					
			C.					
Enter underlying cause last (Disease or injury that initiated events resulting in death)			D.					
Part II. Please list other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Manner of death: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined								
Comments:								
Form Completed by: _____ Area Code and Phone Number: _____ County: _____								