

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

For guidance in contacting families or completing report, refer to Guide for the SID Home Visit at www.odh.ohio.gov or call (330) 929-9911.

Return completed report to: Baby 1st Network, P.O. Box 403, Toledo, Ohio 43697-0403. Or Fax (330) 929-0593