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 ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Non-Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other_____	

Mother's Name			
Last	First	Phone	
Address	City		Zip

Father's Name			
Last	First	Phone	
Address ☐ Same as Mother	City		Zip

Other Family				
Last	First	Relationship	Phone	
Address ☐ Same as Mother	City		Zip	

Family Contact Record				
Date	Type of Contact			Next Steps
	☐ Mail	☐ Phone	☐ Visit	
	☐ Mail	☐ Phone	☐ Visit	
	☐ Mail	☐ Phone	☐ Visit	
	☐ Mail	☐ Phone	☐ 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 ☐ Crib/bassinet ☐ Playpen ☐ Adult Bed ☐ Couch/Chair ☐ Infant Seat ☐ Other _____

Infant placed to sleep ☐ On Back ☐ On Stomach ☐ On Side ☐ Other _____

Infant sharing sleep surface with ☐ Adults ☐ Children ☐ Blankets ☐ Pillows ☐ 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 1-800-477-7437.

Return completed report to: Baby 1st Network, 421 Graham Rd., Suite H, Cuyahoga Falls, Ohio 44221; FAX 330-929-0593