

Ohio Department of Health

Final Diagnosis 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							
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: _____																	

Please send this report to:

Baby 1st Network
 P.O. Box 403
 Toledo, OH 43697-0403
 Or Fax (330) 929-0593

If you have questions regarding this form, please call Stacy Scott, PhD at (330) 929-9911