Ohio Department of Health
Notification of Infant Death

Infant's Name Last First Middle	Date of Birth	Date of Death

Gender	Age	Hispanic Ethnicity	Race (Check all that apply)
□ Male □ Female □ Unknown		□ Yes □ No	□ White □ Black / African American □ American Indian / Alaskan Native □ Hawaiian Native / Pacific Islander □ Asian □ Unknown □ 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

The **Preliminary** diagnosis of this death is:

- □ SIDS
- □ Unintentional Injury / Accident
  - □ Asphyxia
  - □ Other Unintentional Injury
- □ Inflicted Injury / Homicide
- □ Undetermined (Natural)
- □ Undetermined (Not Natural)
- □ Undiagnosed Disease / Natural
- □ Other (Please Explain)

□ Circumstances dictate that **NO** contact with the family should be made until final diagnosis

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 Dr. Stacy Scott at (330) 929-9911