



Coroner Report Form

To Be Completed for All Child Deaths (Ages 0-17)

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A. Identification of decedent			
First Name:	Middle Name:	Last Name:	Suffix:
Alternate First Name:	Alternate Middle Name:	Alternate Last Name:	Alternate Suffix:
Date of Birth (mm/dd/yy)	Date of Death (mm/dd/yy)	Time of Death (Military)	
County, State of Residence	County, State of Injury/Illness Event	County, State of Death	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic	
Manner of Death: <input type="checkbox"/> Natural – excluding SIDS <input type="checkbox"/> Natural - SIDS <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Unintentional Injury (Accident) <input type="checkbox"/> Undetermined <input type="checkbox"/> Pending Investigation			
(If Sudden Unexplained Infant Death (including SIDS) or possible SIDS - complete supplemental form)			
B. Contributing factors (check all that apply)			
<input type="checkbox"/> Lack of supervision <input type="checkbox"/> Alcohol use <input type="checkbox"/> Drug use <input type="checkbox"/> Neglect (Physical, medical, emotional) <input type="checkbox"/> Domestic violence <input type="checkbox"/> Child abuse <input type="checkbox"/> Known illness, specify: <input style="width: 150px;" type="text"/> <input type="checkbox"/> Other, specify: <input style="width: 150px;" type="text"/>			
C. Describe the events and circumstances leading to the fatal illness/event:			
Specify any concerns of abuse, neglect, drug/alcohol involvement, or suspicious circumstances.			
D. Additional information or comments:			

E. Autopsy and investigation information:

Autopsy Status: No autopsy Autopsy completed, report pending Autopsy completed, report sent to SCDRB

Autopsy performed by:

Was toxicology testing performed on the decedent? Yes No Unknown

Toxicology performed by:

If yes, were results: Positive Negative Unknown Pending

If results positive, substance if known:

If results positive, level, if known:

Law Enforcement agency conducting required investigation: _____

Additional death scene investigation performed by: (Mark all that apply)

Not conducted Coroner Fire Investigator Other: Specify _____

F. Other source information (if applicable):

Contact Name	Agency Name	Phone Number	Date (mm/dd/yy)	Case Number

Coroner Name: _____

Submitted by: _____

Phone Number: _____

E-mail: _____

Please forward the information to: Sara Hortenstine, Executive Director
 State Child Death Review Board
 Office of the Attorney General
 120 S.W. 10th Avenue, 2nd Floor
 Topeka, KS 66612
 Phone: (785) 296-7970
 Fax: (785) 296-7796
 E-mail: sara.hortenstine@ag.ks.gov



***SUDDEN UNEXPLAINED INFANT DEATH –
SUPPLEMENTAL INFORMATION***

Page 3 (if indicated)

Decedent's Name:

Date of Death:

Position of infant when placed: Abdomen Back Side Unknown
 Other If other, specify:

Position of infant when found: Abdomen Back Side Unknown
 Other If other, specify:

Sleeping place: Crib Bed, not crib Couch Waterbed Unknown
 Other If other, specify:

Sleeping surface: Firm Soft Unknown

Sleeping arrangement (check all that apply):
 Sleeping alone Bed sharing w/adult Bed sharing w/child
 Unknown Other, specify:

Was bedding or items in or on the decedent's sleeping surface a concern?
 Yes No Unknown

Recent URI (In last 2 wks of life)? Yes No Unknown

Other illness in last 2 wks of life? Yes No Unknown
If yes, specify:

Did anyone in the home smoke? Yes No Unknown

Specify any other risk factors present at the scene: