

Decedent's name	Age	Sex	Race/Ethnicity
Local accession number	Date of birth	Date/time of death	Date of autopsy
Pathologist	County		

1) FINAL CAUSE AND MANNER OF DEATH

2) STUDIES

Routine Studies	Normal	Abnormal	Not Done	Findings
Photographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Full-body X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Toxicology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Histopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Neuropathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Metabolic Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Blood/Tissues for future studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

Studies, as indicated	Normal	Abnormal	Not Done	Findings
Vitreous samples for glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Microbiology/Virology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Genetic Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Electrolytes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
HIV Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

COMMENTS:

3) CLINICAL SUMMARY:

Maternal Age: _____

Birth Weight (in grams): _____ Gestational Age: _____

Pregnancy Complications: _____

Medical History	YES	NO	NOT AVAILABLE	COMMENTS
Maternal Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling with SIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Relative with SIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Infant or Child Deaths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sleeping Position (put to sleep): Supine Prone Side Unknown

Co-Sleeping: Yes No Unknown

Describe sleep habits and bedding, if known: _____

COMMENTS:

4) DEATH SCENE INVESTIGATION

Indicated If indicated, state date: _____

Not indicated If not indicated, state reason: _____

COMMENTS:

Autopsy Format

- Final Diagnoses
- Final Cause and Manner of Death
- External Examination
- Postmortem Changes
- Scars / Other Distinguishing Characteristics
- Clothing
- Weights and Measures
- General Appearance / Development
- Injuries (External and Internal)
- Therapeutic Procedures
- Resuscitation Evidence
- External Integument
- Internal Examination
 - Head
 - Neck
 - Body Cavities
 - Cardiovascular System
 - Respiratory System
 - Liver, Gallbladder and Pancreas
 - Hemolymphatic System
 - Genitourinary System
 - Endocrine System
 - Digestive System
 - Musculoskeletal System
- Post-Mortem Studies
 - Full body X-rays
 - Histopathology
 - Toxicology
 - Metabolic Screen
 - Neuropathology
 - Cultures
 - Blood/Tissue retained for future studies
 - Other