SBS INTAKE FORM

2nd Chair Services

CASE NAME					
ATTORNEY					
Name:		Firm			
Address:					
Phone:		FAX:			
Cell:		E-mail			
DEFENDANT					
NAME					
Date of Birth		In custody?	NO		YES
Phone		Work			
Cell		E-mail			
Address:					
Age:	Gender:	Race:	Height:	Weight:	
Relationship to baby:					
Experience taking care of children:					
Number of children:	Girls:	Boys:			
Any Priors?	NO		YES		Comments:
Admitted to shaking?	NO		YES		Comments:
Baby					
Name:			Date of Birth:		
Age:	Gender:	Race:	Date of "Incident":		
Status:					
POINT OF CONTACT					
Name:		Firm			
Address:					
Phone:		FAX:			
Cell:		E-mail			
Notes:					

MEDICAL FINDINGS			
Visible impact site		Where?	
External bruises		Where?	
Subdural		Where?	
Sub-Galeal		Where?	
Subarachnoid		Where?	
Skull fractures		Where?	
Other injuries to Head/Face		Where?	
Old Subdurals		Where?	
Diffuse axonal injury(ies)		Where?	

RETINAL HEMORRHAGES			
Type of Hemorrhage(s)	Bilateral	Unilateral R L	
Petechiae	Dot Blot Hemorrhages	Flame Shaped Hemorrhages	Nerve Sheath Hemorrhages

OTHER INJURIES TO BODY? PLEASE DESCRIBE (FRACTURES, BRUISES, MARKS)						
Neck	NO		YES		Comment:	
Throat	NO		YES		Comment:	
Rib Cage/Chest	NO		YES		Comment:	
Back	NO		YES		Comment:	
Abdomen	NO		YES		Comment:	
Arms	NO		YES		Comment:	
Under arms	NO		YES		Comment:	
Hands/Fingers	NO		YES		Comment:	
Legs	NO		YES		Comment:	
Feet/Toes	NO		YES		Comment:	

Notes:

CASE SCENARIO

Were police/911 called?	NO		YES		By Whom:	
Was an ambulance sent?	NO		YES		Agency:	
Was FULL CPR given?	NO		YES		By Whom:	
Was rescue breathing given?	NO		YES		By Whom:	
At the time of CPR was there a heartbeat or breathing by the baby?	NO		YES			
Was a fall or drop reported?	NO		YES			

If yes, please describe fall:

Was baby taken to a hospital?	YES	NO	
Any other falls or drops, other than this event, in which the head was struck?	YES	NO	If yes, please describe:

Has the baby had any of the following medical tests performed?

Blood Tests	YES	NO	Cat Scans or MRI's	YES	NO
Spinal Tap	YES	NO	GA-1	YES	NO

BABY'S MEDICAL HISTORY

Pregnancy

Baby's Mother

Age	Race:	Wt	Ht	Occupation:
Experience taking care of children:				
Number of children:	Girls	Boys		

Baby's Father

Age	Race:	Wt	Ht	Occupation:
Experience taking care of children:				
Number of children:	Girls	Boys		

Was Pregnancy Planned?	YES	NO	
Pre-Natal Care:	YES	NO	If yes, give Doctor'
Smoking during pregnancy?	YES	NO	Packs per day:
Complicated Pregnancy/Chilbirth?	YES	NO	

If yes, Please Describe:

LABOR AND BIRTH

Weight		Length:		Temperature:		Blood Type:	
Head circumference:		Shape:					
APGARS Score:	1 Min		5 Min		10 Min		
Gestation period:		Time in labor:					

Labor and Delivery:

Vaginal	NO		YES		Comment:	
Multiple Birth baby?	NO		YES		Birth Ord	
C-Section	NO		YES		Comment:	
Breech	NO		YES		Comment:	
Forceps Used	NO		YES		Comment:	
Premature	NO		YES		Comment:	
Medication during labor?	NO		YES		Comment:	
Anesthesia?	NO		YES		Comment:	
Epidural?	NO		YES		Comment:	

Vaccinations and Medications					
Number of days since last vaccination:		Number of vaccination (1st, 2nd, etc.):			
Any calls into the doctor around vaccination days?	NO		YES		If yes, please explain below:
Regular Pediatric Care?	NO		YES		
Was the baby sick when vaccinated?	NO		YES		If yes, please explain below:
Please list below which vaccines were administered and when:					
Vaccination # 1	Date	Please list the name and lot numbers of the vaccines			
Vaccination # 2	Date:	Please list the name and lot numbers of the vaccines			
Vaccination # 3	Date:	Please list the name and lot numbers of the vaccines			

D and C performed?	NO		YES		Comment:	
Vitamin K shot given?	NO		YES		Comment:	
Was the baby breast -fed?	NO		YES		Comment:	
Was the baby only fed formula?	NO		YES		Type of formula:	
Amniocentesis performed?	NO		YES		Comment:	

Doctor Visits:

How many trips has the baby had to the doctor? List dates and for what purpose(s) below . Put Time Line of Baby's Medical History Here

Did the baby seem healthy prior to the event?	NO		YES		If no, please explain below:

Notes:

Please explain below any medical abnormalities you think we should know about:

Prior to the death of the baby had the baby experienced any of the following symptoms:						
Lethargy	NO		YES		Comment:	
Vomiting	NO		YES		Comment:	
Failure to feed	NO		YES		Comment:	
Inconsolable crying	NO		YES		Comment:	
Crying when laid down	NO		YES		Comment:	
Increase in head size	NO		YES		Comment:	
Excessive Fever	NO		YES		Comment:	
Respiratory tract infections	NO		YES		Comment:	
Seizures	NO		YES		Comment:	
Shivers	NO		YES		Comment:	
Staring spells	NO		YES		Comment:	
Twitches	NO		YES		Comment:	
Unusual weight gain/loss	NO		YES		Comment:	
Tenderness to touch	NO		YES		Comment:	
Change in Behavior	NO		YES		Comment:	
History of Sickness	NO		YES		Comment:	
Held head in special position	NO		YES		Comment:	
Regression in development	NO		YES		Comment:	
Dizziness	NO		YES		Comment:	
Irregular gait	NO		YES		Comment:	
Clumsiness	NO		YES		Comment:	

Notes:

CASE SUMMARY- NOTES