Rapid Response Child Death Reporting Form

*County_____ *CFR Coordinator_____

*Health Department_____ Phone _____

*Date CFR Coordinator notified of death _____ Coroner/Dep. Coroner_____

Items marked with an asterisk must be completed. Please fax or e-mail this form to: Sherry Rock, Child Fatality Review Program Administrator at **502-564-5766 or sherry.rock@ky.gov within 24 hours of receiving notice of child's death.**

1. ***Child's name**: First:_____ Middle:_____ Last:_____

2. ***Date of death**: _____ 3. Date of birth: _____ 4. Age:_____

5. Race, check all that apply: ☐ White ☐ Black ☐ Asian

☐ Native American ☐ Other, please specify _____

6. Hispanic or Latino origin? ☐ Yes ☐ No

7. ***Gender**: ☐ Male ☐ Female 8. State where child was born_____

9. ***County of Death**: _____

10. County of Residence: _____

11. Residence: City: _____

State: _____ Zip Code: _____

12. ***Circumstances of Death**:

13. Will this case be reviewed by Local CFR Team? ☐ Yes ☐ No

14. How did LHD receive notification of child's death? ☐ Coroner ☐ Parent/Caretaker ☐ Hospital/ER ☐ Law Enforcement ☐ Obituary

Other, please specify_____

This Box to be completed by DPH/MCH

Case Number:

_____/_____/_____/_____

State / County Number / Year of Death / Sequence of Review

Notification received on _____/_____/_____