

San Diego SIDS/SUDC Research Project
Investigation of Sudden, Unexplained Death in Childhood
Obstetrician, Pediatrician, Physician and Medical Examiner List

Please provide the following information for all doctors who were involved in your child's healthcare, including any prenatal (pregnancy) care, and for the medical examiner who examined your child. If you have already requested records from any of these physicians, please note accordingly.

1st Doctor's Name: _____

Doctor's Specialty: _____

Office or Hospital Name: _____

Office/Hospital
Mailing Address: _____

Phone Number: _____

Records requested? Y N

2nd Doctor's Name: _____

Doctor's Specialty: _____

Office or Hospital Name: _____

Office/Hospital
Mailing Address: _____

Phone Number: _____

Records requested? Y N

3rd Doctor's Name: _____

Doctor's Specialty: _____

Office or Hospital Name: _____

Office/Hospital
Mailing Address: _____

Phone Number: _____

Records requested? Y N

4th Doctor's Name: _____
Doctor's Specialty: _____
Office or Hospital Name: _____
Office/Hospital
Mailing Address: _____

Phone Number: _____
Records requested? Y N

Medical Examiner's Name: _____
Office County/State: _____
Mailing Address: _____

Phone Number: _____

YOUR CHILD'S INFORMATION:

Your child's name: _____
Your child's date of birth: _____
Your child's date of death: _____

YOUR NAME AND CONTACT INFORMATION:

Name(s): _____
Your relationship to child: _____
Address: _____

Phone #: _____
E-mail: _____

WE MAY CONTACT YOU BY: PHONE: _____ E-MAIL: _____ MAIL: _____

CONCURRENT RESEARCH

Are you a participant, or do you plan to enroll, in any other research for your child? Y N
Please specify _____