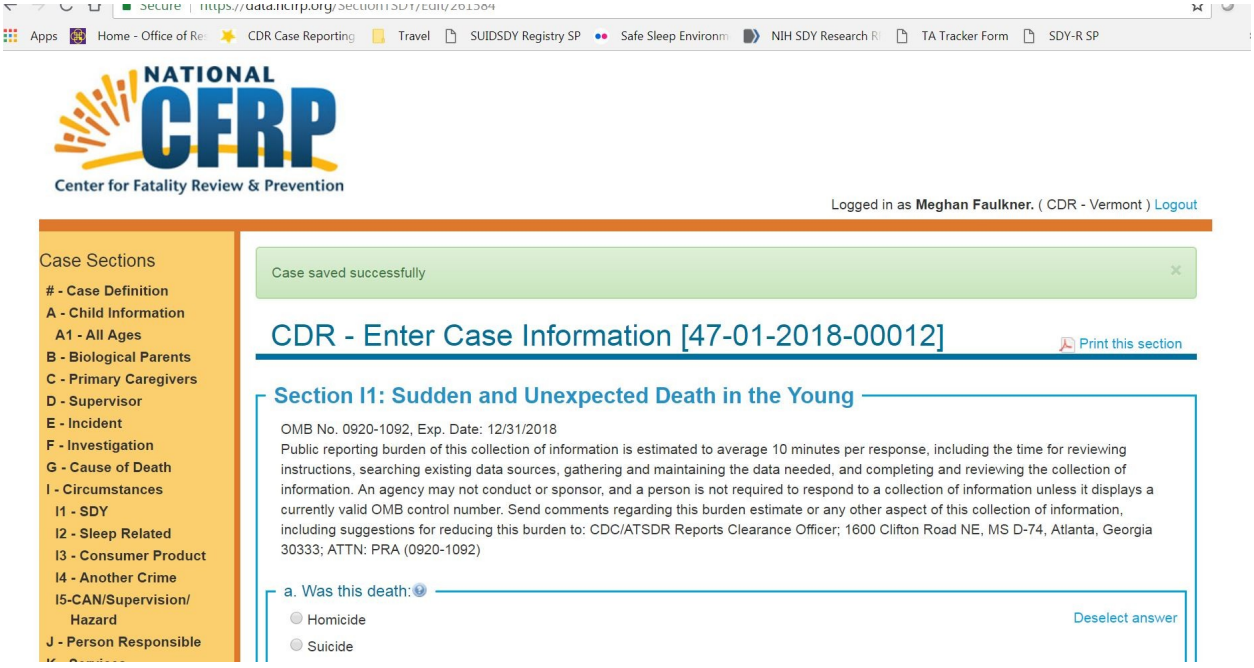
Form Approved
OMB Number: 0920-1092
Expiration Date: XX/XX/2022

Attachment 7a: NCFRP Case Reporting System - SDY Module Section I



I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

I1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)

This section displays online based on your state's settings.

Section I1: OMB No. 0920-1092, Exp. Date: 12/31/2018

a. Was this death:

- ○ A homicide?
- ○ A suicide?
- ○ An overdose?
- ○ A result of an external cause that was the obvious and only reason for the fatal injury?
- ○ Expected within 6 months due to terminal illness?

If any of these apply, go to Section I2, THIS IS NOT AN SDY CASE.

- ○ None of the above, go to I1b THIS IS AN SDY CASE
- ○ Unknown, go to I1b

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death? ☐ U/K for all

Symptom	Present w/in 72 hours of death			Other Acute Symptoms	Present w/in 72 hours of death		
Cardiac	Yes	No	U/K		Yes	No	U/K
Chest pain	○	○	○	Fever	○	○	○
Dizziness/lightheadedness	○	○	○	Heat exhaustion/heat stroke	○	○	○
Fainting	○	○	○	Muscle aches/cramping	○	○	○
Palpitations	○	○	○	Slurred speech	○	○	○
Neurologic				Vomiting	○	○	○
Concussion	○	○	○	Other, specify:	○		
Confusion	○	○	○				
Convulsions/seizure	○	○	○				
Headache	○	○	○				
Head injury	○	○	○				
Psychiatric symptoms	○	○	○				
Paralysis (acute)	○	○	○				
Respiratory							
Asthma	○	○	○				
Pneumonia	○	○	○				
Difficulty breathing	○	○	○				

c. At any time more than 72 hours preceding death did the child have a personal history of any of the following chronic conditions or symptoms? ☐ U/K for all

Symptom	Present more than 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Respiratory			
Difficulty breathing	○	○	○
Other			
Slurred speech	○	○	○
Other, specify:	○		

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

○ Yes ○ No ○ U/K If yes, describe:

e. Had the child ever been diagnosed by a medical professional for the following? ☐ U/K for all

Condition	Diagnosed			Condition	Diagnosed			Condition	Diagnosed		
Blood disease	Yes	No	U/K	**Neurologic**	Yes	No	U/K	**Other**	Yes	No	U/K
Sickle cell disease	○	○	○	Anoxic brain Injury	○	○	○	Connective tissue disease	○	○	○
Sickle cell trait	○	○	○	Traumatic brain injury/	○	○	○	Diabetes	○	○	○
Thrombophilia (clotting disorder)	○	○	○	head injury/concussion				Endocrine disorder, other:	○	○	○
Cardiac				Brain tumor	○	○	○	thyroid, adrenal, pituitary			
Abnormal electrocardiogram	○	○	○	Brain aneurysm	○	○	○	Hearing problems or deafness	○	○	○
(EKG or ECG)				Brain hemorrhage	○	○	○	Kidney disease	○	○	○
Aneurysm or aortic dilatation	○	○	○	Developmental brain disorder	○	○	○	Mental illness/psychiatric disease	○	○	○
Arrhythmia/arrhythmia syndrome	○	○	○	Epilepsy/seizure disorder	○	○	○	Metabolic disease	○	○	○
Cardiomyopathy	○	○	○	Febrile seizure	○	○	○	Muscle disorder or muscular	○	○	○
Commotio cordis	○	○	○	Mesial temporal sclerosis	○	○	○	dystrophy			
Congenital heart disease	○	○	○	Neurodegenerative disease	○	○	○	Oncologic disease treated by	○	○	○
Coronary artery abnormality	○	○	○	Stroke/mini stroke/	○	○	○	chemotherapy or radiation			
Coronary artery disease	○	○	○	TIA-Transient Ischemic Attack				Prematurity	○	○	○
(atherosclerosis)				Central nervous system infection	○	○	○	Congenital disorder/	○	○	○
Endocarditis	○	○	○	(meningitis or encephalitis)				genetic syndrome			
Heart failure	○	○	○	**Respiratory**				Other, specify:	○		
Heart murmur	○	○	○	Apnea	○	○	○				
High cholesterol	○	○	○	Asthma	○	○	○				
Hypertension	○	○	○	Pulmonary embolism	○	○	○				
Myocarditis (heart infection)	○	○	○	Pulmonary hemorrhage	○	○	○				
Pulmonary hypertension	○	○	○	Respiratory arrest	○	○	○				
Sudden cardiac arrest	○	○	○								

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply: ☐ None

☐ Cardiac ablation
☐ Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))
☐ Heart surgery
☐ Interventional cardiac catheterization
☐ Heart transplant
☐ Other, specify:
☐ U/K

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms? ☐ U/K for all

Y	N	U/K	Deaths
○	○	○	Sudden unexpected death before age 50

Heart Disease

○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease

Neurologic Disease

○	○	○	Epilepsy or convulsions/seizure
○	○	○	Other neurologic disease

Y	N	U/K	Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting

Other Diagnoses

○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○			Other diseases that are genetic or run in families, specify:

If sudden unexpected death before age 50, describe the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?
○ Yes ○ No ○ U/K

If yes, describe the test/gene tested, reason for testing, family member tested, and results:

Was a gene mutation found?
○ Yes ○ No ○ U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?
○ Yes ○ No ○ U/K
If yes, describe:

i. Within 2 weeks prior to death had the child:

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	○	○	○	○
Missed doses of prescribed medications	○	○	○	○
Changed prescribed medications, describe:	○	○	○	○

j. Was the child compliant with their prescribed medications?
○ N/A ○ Yes ○ No ○ U/K
If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death? Check all that apply:

☐ Over-the-counter medicine
☐ Recent/short term prescriptions
☐ Energy drinks
☐ Caffeine
☐ Performance enhancers
☐ Diet assisting medications
☐ Supplements
☐ Tobacco
☐ Alcohol
☐ Illegal drugs
☐ Legalized marijuana
☐ Other, specify:
☐ U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident? ☐ U/K for all at time of incident ☐ U/K for all within 24 hours of incident

Stimuli	At incident Yes	At incident No	At incident U/K	Within 24 hrs of incident Yes	Within 24 hrs of incident No	Within 24 hrs of incident U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other, specify:	○			○		

If yes to physical activity, describe type of activity:
At incident Within 24 hours of incident

Other specify:
At incident Within 24 hours of incident

m. Was the child an athlete? ○ N/A ○ Yes ○ No ○ U/K
If yes, type of sport: ○ Competitive ○ Recreational ○ U/K
If competitive, did the child participate in the 6 months prior to death? ○ Yes ○ No ○ U/K

n. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

☐ Chest pain
☐ Confusion
☐ Convulsions/seizure
☐ Dizziness/lightheadedness
☐ Fainting
☐ Headache
☐ Palpitations
☐ Shortness of breath/difficulty breathing
☐ Other, specify:
☐ U/K

If yes to any item, describe type of physical activity and extent of symptoms:

o. For child age 12 or older, did the child receive a pre-participation exam for a sport?
○ N/A ○ Yes ○ No ○ U/K
If yes:
Was it done within a year prior to death? ○ Yes ○ No ○ U/K
Did the exam lead to restrictions for sports or otherwise? ○ Yes ○ No ○ U/K
If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

p. How old was the child when diagnosed with epilepsy/seizure disorder?

Age 0 (infant) through 20 years: _____

☐ U/K

q. What were the underlying cause(s) of the child's seizures? Check all that apply:

☐ Brain injury/trauma, specify:
☐ Brain tumor
☐ Cerebrovascular
☐ Central nervous system infection
☐ Degenerative process
☐ Developmental brain disorder
☐ Inborn error of metabolism
☐ Genetic/chromosomal
☐ Mesial temporal sclerosis
☐ Idiopathic or cryptogenic
☐ Other acute illness or injury other than epilepsy
☐ Other, specify:
☐ U/K

r. What type(s) of seizures did the child have? Check all that apply:

☐ Non-convulsive
☐ Convulsive (grand mal seizure or generalized tonic-clonic seizure)
☐ Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)
☐ U/K

s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:

☐ Last less than 30 minutes
☐ Last more than 30 minutes (status epilepticus)
☐ Occur in the presence of fever (febrile seizure)
☐ Occur in the absence of fever
☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

t. How many seizures did the child have in the year preceding death?

○ 0/never ○ 2 ○ More than 3
○ 1 ○ 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?

○ Yes ○ No ○ U/K

If yes, how many different types of anti-epileptic drugs did the child take?

○ 1 ○ 4 ○ More than 6
○ 2 ○ 5 ○ U/K
○ 3 ○ 6

v. Was night surveillance used?

○ Yes ○ No ○ U/K