



# STANDARDIZED AUTOPSY PROTOCOL

## For the Evaluation of Sudden, Unexpected Infant Death



This *Standardized Autopsy Protocol* (CDPH 4437), for the evaluation of sudden, unexpected infant death, has been approved by the California Department of Public Health (CDPH) pursuant to Government Code, Section 27491.41. Beginning January 1, 2006, this Protocol is available for use throughout California to assist medical examiners and coroners to establish the mode, manner, and cause of death for all infants one year of age or younger who die suddenly and unexpectedly and in whom the causes of death are not obvious.

The coroner shall state on the death certificate that Sudden Infant Death Syndrome (SIDS) was the cause of death when the coroner's findings are consistent with the following definition:

**The sudden death of an infant one year of age or younger which is unexpected by the infant's history and where a thorough postmortem examination including an autopsy, death scene investigation and review of the infant's medical history fails to demonstrate an adequate cause of death.**

Gross autopsy findings should be recorded by completing the checklist on the left-hand side of the page and a narrative description added as needed on the right-hand side of the page. Any reports of ancillary studies, including microscopic findings, toxicology, analyses, microbiologic cultures, and other studies can be attached to and submitted with this document.

If this Protocol is used and completed for the investigation of a sudden, unexplained infant death, the CDPH would appreciate a copy of this Protocol, as well as the *Death Scene and Deputy Coroner Investigation Protocol* (CDPH 4439), to be sent to:

**Maternal, Child, and Adolescent Health  
California Department of Public Health  
P.O. Box 997420, MS 8304  
Sacramento, CA 95899-7420**  
(916) 650-0323 (phone)      [Carrie.Florez@cdph.ca.gov](mailto:Carrie.Florez@cdph.ca.gov) (email)

Additional copies of this Protocol can be obtained from the CDPH at the contact information listed above or by accessing the CDPH website at <http://www.cdph.ca.gov/programs/SIDS/Pages/4.5SIDSProtocol.aspx>

# STATE OF CALIFORNIA STANDARDIZED AUTOPSY PROTOCOL

Please Type or Print

<b>Decedent's Name (Last, First, Middle)</b>						<b>Sex</b>	
						<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<b>Date of Birth</b>			<b>Age</b>	<b>Date of Death</b>			<b>Time of Death</b>
Mo	Day	Yr		Mo	Day	Yr	
<b>Race/Ethnicity</b>				<b>Date of Autopsy</b>			<b>Time of Autopsy</b>
				Mo	Day	Yr	
<b>Pathologist</b>				<b>County</b>			<b>Local accession number</b>

## FINAL ANATOMIC DIAGNOSES

MICROBIOLOGY RESULTS

TOXICOLOGY RESULTS

CHEMISTRY RESULTS

PATHOLOGIST \_\_\_\_\_

<b>Decedent's Name</b>		<b>County</b>		
<b>Accession Number</b>		<b>Pathologist</b>		
I. RECOMMENDED AS INDICATED				Comments
1. Viruses, trachea, stool	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
2. Bacteria, blood, CSF, fluids	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
3. Fungi, discretionary	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
4. Mycobacteria, discretionary	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
5. Bacteria, liver, lung, and myocardium	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
6. Viruses, liver, lung, and myocardium	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
7. PHOTOGRAPHS, INCLUDE				
a. Name, case number, county, country, date	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Measuring device, color reference	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Consider front and back	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Gross abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
8. RADIOGRAPHIC STUDIES				
a. Whole body	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Thorax and specific lesions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
II. WEIGHTS AND MEASURES				
9. Body weight	_____ gm			
10. Crown-heel length	_____ cm			
11. Crown-rump length	_____ cm			
12. Occipitofrontal circumference	_____ cm			
13. Chest circumference at nipples	_____ cm			
14. Abdominal circumference at umbilicus	_____ cm			
III. GENERAL APPEARANCE/DEVELOPMENT				
15. Development normal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
16. Nutritional status	<input type="checkbox"/> NORMAL	<input type="checkbox"/> POOR	<input type="checkbox"/> OBESSE	<input type="checkbox"/> NO EXAM
17. Hydration	<input type="checkbox"/> NORMAL	<input type="checkbox"/> DEHYDRATED	<input type="checkbox"/> EDEMATOUS	<input type="checkbox"/> NO EXAM
18. Pallor	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
19. HEAD				
a. Configuration normal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Scalp and hair normal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Bone consistency normal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	

<b>Decedent's Name</b>		<b>County</b>			
<b>Accession Number</b>		<b>Pathologist</b>			
<b>III. GENERAL APPEARANCE/DEVELOPMENT</b>			<b>Comments</b>		
20. TRAUMA EVIDENCE					
a. Bruises	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Lacerations	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
c. Abrasions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
d. Burns	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
e. Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
21. PAST SURGICAL INTERVENTION					
a. Scars	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
22. RESUSCITATION EVIDENCE					
a. Facial mask marks	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Lip abrasions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
c. Chest ecchymoses	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
d. EKG monitor pads	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
e. Defibrillator marks	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
f. Venipunctures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
g. Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
<b>IV. EXTERNAL EXAMINATIONS</b>					
23. Congenital anomalies, external					
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
24. INTEGUMENT					
a. Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Petechiae	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
c. Rashes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
d. Birthmark	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
e. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
25. EYES					
a. Color (check)	<input type="checkbox"/> BROWN	<input type="checkbox"/> BLUE	<input type="checkbox"/> GREEN	<input type="checkbox"/> HAZEL	<input type="checkbox"/> NO EXAM
b. Cataracts	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Position abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
d. Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
e. Conjunctiva abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
f. Petechiae	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
g. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM

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IV. EXTERNAL EXAMINATIONS			Comments
26. EARS			
a. Low set	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Rotation abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
27. NOSE			
a. Discharge	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Describe if present _____			
b. Configuration abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Septal deviation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
d. Right choanal atresia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
e. Left choanal atresia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
f. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
28. MOUTH			
a. Discharge	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Describe if present _____			
b. Labial frenulum abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Specify _____			
c. Teeth present	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Number of upper _____			
Number of lower _____			
29. TONGUE			
a. Abnormally large	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Frenulum abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
30. PALATE			
a. Cleft	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. High arched	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
31. MANDIBLE			
a. Micrognathia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
32. Neck abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
33. Chest abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM

Decedent's Name		County	
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IV. EXTERNAL EXAMINATIONS			Comments
34. ABDOMEN			
a. Distended	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Umbilicus abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Hernias	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
d. Other abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
35. External genitalia abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
36. Anus abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
37. Extremities abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
VI. INTERNAL EXAMINATION			
38. Subcutis thickness 1 cm below umbilicus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
39. Subcutaneous emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
40. Situs inversus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
41. PLEURAL CAVITIES abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Fluid (describe if present) _____			
Right _____ ml			
Left _____ ml			
42. PERICARDIAL CAVITY abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Fluid (describe if present) _____			ml
43. Retroperitoneum abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
44. PETECHIAE			
a. Parietal pleura right	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
If yes	<input type="checkbox"/> Dorsal	<input type="checkbox"/> Ventral	<input type="checkbox"/> Dorsal & Ventral
b. Parietal pleura left	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
If yes	<input type="checkbox"/> Dorsal	<input type="checkbox"/> Ventral	<input type="checkbox"/> Dorsal & Ventral
c. Visceral pleura right	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
If yes	<input type="checkbox"/> Dorsal	<input type="checkbox"/> Ventral	<input type="checkbox"/> Dorsal & Ventral
d. Visceral pleura left	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
If yes	<input type="checkbox"/> Dorsal	<input type="checkbox"/> Ventral	<input type="checkbox"/> Dorsal & Ventral
45. UPPER AIRWAY OBSTRUCTION			
a. Foreign body	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Mucus plug	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM

Decedent's Name		County		
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VI. INTERNAL EXAMINATION				Comments
46. Neck Soft Tissue Hemorrhage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
47. Hyoid Bone abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
48. THYMUS				
a. Weight			_____ gm	
b. Atrophy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
49. Epiglottis abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
50. LARYNX abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
Narrowed lumen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
51. TRACHEA abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Stenosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Obstructive exudates	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Aspirated gastric contents	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. ET tube tip location	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
52. MAINSTEM BRONCHI abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Edema Fluid	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Mucus plugs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Gastric contents	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Inflammation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
53. LUNGS				
a. Total Weight			_____ gm	
Right			_____ gm	
Left			_____ gm	
b. Abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Congestion	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
If yes, describe location	_____			
Severity	<input type="checkbox"/> Slight/Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy/Marked <input type="checkbox"/> Diffuse	
d. Hemorrhage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
If yes, describe location	_____			
Severity	<input type="checkbox"/> Slight/Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy/Marked <input type="checkbox"/> Diffuse	
e. Edema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
If yes, describe location	_____			
Severity	<input type="checkbox"/> Slight/Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy/Marked <input type="checkbox"/> Diffuse	

<b>Decedent's Name</b>		<b>County</b>	
<b>Accession Number</b>		<b>Pathologist</b>	
f. Consolidation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM If yes, describe location _____ Severity <input type="checkbox"/> Slight/Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy/Marked <input type="checkbox"/> Diffuse			<b>Comments</b>
<b>VI. INTERNAL EXAMINATION</b>			
g. Anomalies <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
h. Pulmonary artery thromboembolization <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
54. Pleura abnormal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
55. RIBS abnormal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
a. Fractures with hemorrhages <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
b. Callus formation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
c. Configuration abnormal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
56. DIAPHRAGM abnormal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
57. CARDIOVASCULAR SYSTEM <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
a. Heart weight _____ gm			
b. Left ventricular thickness _____ mm			
c. Right ventricular thickness _____ mm			
d. Septal thickness maximum _____ mm			
e. Mitral valve circumference _____ cm			
f. Aortic valve circumference _____ cm			
g. Tricuspid valve circumference _____ cm			
h. Pulmonary valve circumference _____ cm			
i. Myocardium abnormal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
j. Ventricular inflow/out flow tracts narrow <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
k. Valvular vegetations/thromboses <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
l. Aortic coarctation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
m. Patent ductus arteriosus <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
n. Chamber blood (check) <input type="checkbox"/> fluid <input type="checkbox"/> dotted			
o. Congenital heart disease <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
p. Atrial septal defect <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
q. Ventricular septal defect <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
r. Abnormal pulmonary venous connection <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			
s. Other <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO EXAM			

Decedent's Name		County	
Accession Number		Pathologist	
			Comments
t. Location of vascular catheter tips _____			
u. Occlusive vascular thrombosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
If yes, location(s) _____			
v. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
58. Esophagus abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
59. STOMACH abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Describe contents and volume _____			
60. SMALL INTESTINE abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Hemorrhage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Volvulus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Describe contents _____			
61. COLON abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Congestion	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Hemorrhage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
c. Describe contents _____			
62. Appendix abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
63. Mesentery abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Hemorrhage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
b. Possible scar tissues	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
64. LIVER abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Weight _____ gm			
65. Gallbladder abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
66. Pancreas abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
67. SPLEEN abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
Weight _____ gm			
68. KIDNEYS abnormal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM
a. Weight, right		_____ gm	
b. Weight, left		_____ gm	
c. Total weight		_____ gm	



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				Comments		
i. Foramen magnum abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
m. Hemorrhage, estimate volumes (ml)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Epidural _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Dural _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Subdural _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Subarachnoid _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Intracerebral _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Cerebellum _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Brainstem _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Spinal cord _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Intraventricular _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Other _____ ml	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
n. Dural lacerations	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
o. Dural sinus thrombosis	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
78. BRAIN (if externally abnormal, fix before cutting)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
a. Configuration abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
b. Hydrocephalus	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
c. Gyral pattern abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
d. Cerebral edema	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
e. Herniation	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Uncal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
Tonsillar	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
f. Tonsillar necrosis	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
g. Leptomeningeal exudates (culture)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
h. Cerebral contusions	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
i. Malformations	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
j. Cranial nerves abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
k. Circle of Willis/basilar arteries abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
l. Ventricular contours abnormal	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
m. Cerebral infarction	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
n. Contusional tears	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM
o. Other abnormalities	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	NO EXAM

Decedent's Name		County		
Accession Number		Pathologist		
79. SPINAL CORD			<b>Comments</b>	
a. Inflammation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> NO EXAM
b. Contusion(s)	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> NO EXAM
c. Anomalies	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> NO EXAM
d. Other abnormalities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
80. MANDATORY SECTIONS TAKEN				
a. Skin, if lesions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Thymus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Lymph node	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Epiglottis, vertical	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
e. Larynx, glottic, transverse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
f. Trachea and thyroid, transverse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
g. Trachea at carina, transverse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
h. Lungs, all lobes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
i. Diaphragm	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
j. Heart, septum, and ventricles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
k. Gastroesophageal junction	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
l. Terminal ileum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
m. Rectum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
n. Liver	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
o. Mesentery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
p. Pancreas with duodenum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
q. Spleen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
r. Kidney with capsule	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
s. Adrenal	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
t. Rib with costochondral junction	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
u. Pontomedullary junction	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
v. Pons	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
w. Midbrain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
x. Hippocampus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
y. Frontal lobe	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
z. Cerebellum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
aa. Choroid plexus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	

Decedent's Name		County		Comments
Accession Number		Pathologist		
81. OIL RED O STAINED SECTIONS, IF INDICATED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Heart	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Liver	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Muscle	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
82. DISCRETIONARY MICROSCOPIC SECTIONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Supraglottic soft tissue	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Lung hilum	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Pancreatic tail	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Submandibular gland	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
e. Cervical spinal cord	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
f. Mesentery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
g. Stomach	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
h. Colon	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
i. Appendix	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
j. Testes or ovaries	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
k. Urinary bladder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
l. Psoas muscle	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
m. Palatine tonsils	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
n. Basal ganglia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
<b>VII. METABOLIC DISORDERS</b>				
87. Retain on filter paper in all cases	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Whole blood (take large enough sample)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Urine (1 drop)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Hair (taped down)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
<b>VIII. TOXICOLOGY AND ELECTROLYTES</b>				
88. Fluid and tissues saved for one year	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
a. Whole blood and serum save at - 70°C & +4°C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
b. Liver, save 100 gms at - 70°C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
c. Urine, save at - 70°C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
d. Bile	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
e. Vitreous humor	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	
f. Gastric contents	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM	

Decedent's Name		County			
Accession Number		Pathologist			
				Comments	
89. Analyses performed, but not limited to:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
a. Cocaine and metabolites	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Morphine and metabolites	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
c. Amphetamine and metabolites	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
d. Volatiles (ethanol, acetone, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
e. Other indicated by history and exam	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
90. FROZEN TISSUES, save at - 70°C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
a. Lung	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
b. Heart	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
c. Liver	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
d. Lymph node	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NO EXAM		
<p>It is suggested that upon completion of the autopsy that tissues samples be returned to the family if requested due to cultural beliefs. For example, in the Native American population all of the decedent's possessions and body tissues are desirable for a proper burial.</p> <p>If the brain is not cut until after it is fixed, you need the fixed total weigh to compare with the fixed brainstem-cerebellum weight because the brainstem should not be cut off until the time of the examination, which may be after fixation. Keep the rib section or some bone section as mandatory because it allows for examination of the bone marrow.</p>					