SBS INTAKE FORM
EBMSI Group

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: Female	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	Not sure?
Pre-Natal Care:	YES	NO	If yes, give Doctor's Name
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:	

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			

Epidural?	NO		YES		Comment:	
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:

Were any of the following symptoms experienced by the baby prior to injury?						
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