

**NOTE:** For child abuse cases, use the generic SDT list ([http://bit.ly/Generic\\_MR\\_SDT](http://bit.ly/Generic_MR_SDT)) for the following admissions:

1. Mother's Labor and Delivery/childbirth records
2. Child's birth records
3. Date of incident

*In addition, request the following for the following admissions/clinic visits:*

1. Mother's Labor and Delivery/childbirth records including:
  - Delivery Record
  - Operative Note (specify c-section)
2. Child's birth records
  - Neonatal/newborn assessment reports
  - APGAR scores
  - Delivery Record
3. Mother's Prenatal Clinic Visits
  - Clinic notes
  - genetic testing and amniocentesis (if done)
  - Prescription/medication orders
4. Well-child Visits to pediatrician/MD/clinic
  - Clinic notes
  - Vaccination schedules
  - Prescription/medication orders
5. From date of incident:
  - Fire department reports (request direct from fire department)
  - Paramedic reports (request direct from ambulance company)
  - Police reports
  - CPS reports
6. If fatal:
  - Autopsy
  - Any documentation from the hospital related to the death including:
    - i. organ procurement
    - ii. brain death determination
    - iii. EEG
    - iv. code sheets