

12. UNSCHEDULED POSTNATAL FOLLOW-UP NEONATE

- 12.1. Place Korogwe Town Council Hospital Home Other
 12.1.1. If other, specify: _____
- 12.2. Date of investigation (dd/mm/yyyy) ____ / ____ / ____
- 12.3. Time of investigation ____ : ____
- 12.4. Name of midwife/nurse/auxiliary worker: _____
- 12.5. ID of mother (Nb and Initials): M _____
- 12.6. Type of post-natal neonate visit Unscheduled Extra visit
- 12.6.1 Nb of visit --

| 12.7 Sex | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Unknown | | | |
|--|-------------------------------|---------------------------------|----------------------------------|-----------|-----------------------------------|------------------|
| | 1st measurement | 2nd measurement | Diff. between 1st and 2nd | Tolerance | Diff. greater than tolerance? | 3rd measurement |
| 12.8 Weight (g) <input type="checkbox"/> not done | 12.8.1 ____ g | 12.8.2 ____ g | 12.8.3 ____ G | 50g | <input type="checkbox"/> Yes → | 12.8.4 ____ g |

- 12.9. Axillary temperature ____ , ____ °C
 12.9.1. Malformations/congenital disease yes no Unspecified
 12.9.2. If yes, details: _____

- 12.10. Alive yes no
 12.10.1. If no, state date of death ____ / ____ / ____
 12.10.2. If no, state cause of death: _____

- 12.11. If alive, any illness since deliver or today yes no
 12.11.1. If yes, give details: _____

- 12.11.2. If yes, state treatment including time period and doses; _____

Sample collection

- 12.12. mRDT positive Negative Not done
 12.13. HB (hemocue) ____ , ____ g/dL Not done
 12.13.1. If done, type of blood: Venous Heel prick
 12.13.2. Time of sample collection: _____ (24h format)
 12.14. Other test specify: _____

- 12.15. Disease diagnosed today:
- | | | |
|----------------------------------|------------------------------|-----------------------------|
| 12.15.1. Malaria | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.2. Anemia | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.3. Diarrhea | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.4. HIV | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.5. Resp. tract infection | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.6. Urinary tract infection | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.7. Skin rash | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 12.15.8. Others: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- 12.15.8.1. If respiratory illness or others, specify: _____

12.16. Treatment prescribed today yes no

If yes, specify name, dosage and duration of treatment:

12.16.1. 1st: _____

12.16.2. 2nd: _____

12.16.3. 3rd: _____

12.16.4. 4th: _____

12.16.5. Notes _____

12.17. Date of next visit ____ / ____ / ____ Completed follow-up

DATA ENTRY:

1st entry done by: _____ Signature: _____ date: ____ / ____ / ____

2nd entry done by: _____ Signature: _____ date: ____ / ____ / ____