11. POSTNATAL FOLLOW-UP NEONATE

11.1. Place ☐ Korogwe Town Council Hospital ☐ Home ☐ Other
11.1.1. If other, specify:_____
11.2. Date of investigation (dd/mm/yyyy) _ _ / _ _ / _ _ _ _
11.3. Time of investigation __: __
11.4. Name of midwife/nurse/auxiliary worker: _____
11.5. ID of mother (Nb and Initials): M _ _ _ _ _ _ _
11.6. **Type of visit** ☐ **week 4-6**

11.7 Sex ☐ Male ☐ Female ☐ Unknown

	1st measurement	**2nd measurement**	**Diff. between 1st and 2nd**	**Tolerance**	**Diff. greater than tolerance?**	**3rd measurement**
11.8 Weight (g) ☐ not done	11.8.1 __ _____g	11.8.2 __ _____g	11.8.3 __. __G	*50g*	☐ Yes →	11.8.4 __ _____g
11.9 Length (cm) ☐ not done	11.9.1 ____. __cm	11.9.2 ____. __cm	11.9.3 __. __cm	*0.7cm*	☐ Yes →	11.9.4 ____. __cm
11.10 Head circ. (cm) ☐ not done	11.10.1 ____. __cm	11.10.2 ____. __cm	11.10.3 __. __cm	*0.5cm*	☐ Yes →	11.10.4 ____. __cm
11.11 Chest circ. (cm) ☐ not done	11.11.1 ____. __cm	11.11.2 ____. __cm	11.11.3 __. __cm	*0.5cm*	☐ Yes →	11.11.4 ____. __cm
11.12 Abd umbil circ. (cm) ☐ not done	11.12.1 ____. __cm	11.12.2 ____. __cm	11.12.3 __. __cm	*0.5cm*	☐ Yes →	11.12.4 ____. __cm
11.13 MUAC (cm) ☐ not done	11.13.1 ____. __cm	11.13.2 ____. __cm	11.13.3 __. __cm	0.2cm	☐ Yes →	11.13.4 ____. __cm
11.14 Skinfold thickness triceps (mm) ☐ not done	11.14.1 ____. __mm	11.14.2 ____. __mm	11.14.3 __. __ mm	0.4mm	☐ Yes →	11.14.4 ____. __mm
11.15 Skinfold thickness suprailiac (mm) ☐ not done	11.15.1 ____. __mm	11.15.2 ____. __mm	11.15.3 __. __ mm	0.4mm	☐ Yes →	11.15.4 ____. __mm
11.16 Skinfold thickness subscapular (mm) ☐ not done	11.16.1 ____. __mm	11.16.2 ____. __mm	11.16.3 __. __ mm	0.4mm	☐ Yes →	11.16.4 ____. __mm
11.17 Skinfold thickness quadriceps (mm) ☐ not done	11.17.1 ____. __mm	11.17.2 ____. __mm	11.17.3 __. __ mm	0.4mm	☐ Yes →	11.17.4 ____. __Mm

11.18. Axillary temperature _ _ , _ °C
11.19. Malformations/congenital disease ☐ yes ☐ no ☐ Unspecified
11.19.1. If yes, details: _____
_____
_____

11.20. Alive ☐ yes ☐ no
11.20.1. If no, state date of death _ _ / _ _ / _ _ _ _
11.20.2. If no, state cause of death: _____
_____
_____
_____

11.21. If alive, any illness since deliver or today ☐ yes ☐ no

11.21.1. If yes, give details:_____

_____

_____

_____

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

_____

_____

SAMPLE COLLECTED TODAY:

11.22. mRDT ☐ positive ☐ Negative ☐ Not done

11.23. HB (Hemocue) _ _ , _ g/dL ☐ Not done

11.23.1. If done, type of blood: ☐ Venous ☐ Heel prick

11.24. Time of sample collection:_____(24h format)

11.25. Other tests specify_____

11.26.	**Disease diagnosed today:**	☐ yes	☐ no
11.26.1.	Malaria	☐ yes	☐ no
11.26.2.	Anemia	☐ yes	☐ no
11.26.3.	Diarrhea	☐ yes	☐ no
11.26.4.	HIV	☐ yes	☐ no
11.26.5.	Resp. tract infection	☐ yes	☐ no
11.26.6.	Urinary tract infection	☐ yes	☐ no
11.26.7.	Skin rash	☐ yes	☐ no
11.26.8.	Others:		

11.26.9. If respiratory illness or others, specify: _____

_____

11.27. **Treatment** prescribed today ☐ yes ☐ no

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

11.27.1. 1st _____

11.27.2. 2nd _____

11.27.3. 3rd _____

11.27.4. 4th _____

11.28. Date for next visit (dd/mm/yyyy) _ _ / _ _ / _ _ _ _ ☐ Completed follow-up

DATA ENTRY:

1st entry done by:_____Signature:_____ date:_ _/_ _/_ _ _ _

2nd entry done by:_____Signature:_____ date:_ _/_ _/_ _ _ _