

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:** ☐ yes ☐ no
 12.15.1. Malaria ☐ yes ☐ no
 12.15.2. Anemia ☐ yes ☐ no
 12.15.3. Diarrhea ☐ yes ☐ no
 12.15.4. HIV ☐ yes ☐ no
 12.15.5. Resp. tract infection ☐ yes ☐ no
 12.15.6. Urinary tract infection ☐ yes ☐ no
 12.15.7. Skin rash ☐ yes ☐ no
 12.15.8. Others: ☐ yes ☐ 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: _ / _ / _ _ _ _