Household Registration Form

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Offi Household registration number
2082 MTHETWA SHOTI SALAMINA

Clinic name *(DHIS name)*		Ward *(DHIS #)*		**CHW** household identification number	MS 2082
Name of household head/contact				Date of visit *(dd/mm/yyyy)*	*41465*
Household street address/descriptive location				CHW name	
				Team name *(DHIS name)*	
				Household respondent *A = available; N/A = not available; R = refused*	.....
				Were all household members registered in this visit?	.....
Household head phone number					

1. Household member details

a. Name	b. Date of birth *(dd/mm/yyyy)*	c. Age in years	d. Gender: male	d. Gender: female
1				
2				
3				
4				
5				
6				
7				
8				
e. Totals				

2. Information about the house

a. Does the house have electricity?	..... N
b. Is there piped water in the house or in the yard?	.....
c. Is there a working fridge in the house?	.....
d. Is there a toilet in the house?	.....
e. Total number of rooms in the house?	
f. How many grants does the household receive in total?	
g. How many people in the house are currently working?	
h. Name of school(s) for learners	

3. General household screening questions for all households

If YES to any of following questions, refer for further care

Write HH member # in the last column

a. Does anyone in the household have any of the following: *(circle all that apply)* *(refer for sputum test for TB)* Cough that won't go away? ..... Night sweats ..... Weight loss ..... Fever ..... Loss of appetite?	.....	N
b. It is very important to know your HIV status. Would anyone in the household like to have an HIV test? *(refer for HCT)*	.....	N
c. Is there anyone who does not use a family planning method but wants to? *(refer for family planning services)*	.....	N
d. Is there anyone in the household who cannot get out of bed or needs help with daily living activities? *(refer for home-based care)*	.....	N
e. Do any household members need help applying for social grants? *(refer for social services)*	.....	N
f. Is this a child (<18 years) headed household? *(refer for social services)*	.....	N

4. Household screening questions for CHW follow-up

If any of the answers below are YES, this household will need follow-up. Complete page 2 of this form

a. Is anyone in the household currently pregnant or has not had a menstrual period in the last 6 weeks and may be pregnant?	.....	N
b. Has there been a delivery (baby) in the last 6 weeks?	.....	N
c. Are there any children under the age of 5 in the household?	.....	N
d. Is anyone in the household taking daily medication (like TB/ARV/diabetes medication/high BP medication)?	.....	N

Notes:

*****DOES THIS HOUSEHOLD NEED FOLLOW-UP?*****

YES	NO
Complete page 2 of this form	**Write date for next HH re-assessment visit**

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5. Further assessment and screening questions for all households to be followed by CHW *For each question: If the answer is YES, write the household member number(s) from the list of household member names and details on page 1.* *For any other problems you have identifi write this in the last box in detail and indicate HH member number.* *For questions b-g: check RTHB.* *If a referral is needed, write the total number of clients referred to the clinic for each line.* *If the client was referred elsewhere – indicate the reason, the place of referral and number of referral forms issued in box j.*			**HH member number(s)***	**Number of *Referral Forms* issued**
a. If someone in the house is pregnant, what is the estimated delivery date (EDD)? *Check the ANC card if available or ask mother when her LNMP was and use pregnancy wheel to estimate.* *(Write unknown if delivery date is not known)*	EDD *(dd/mm/yy)*			
b. If there was a birth in the last 6 weeks, what was the date? *Check the RTHB or ask mother for the date of births*	Date of Birth *(dd/mm/yy)*			
i. Was the baby's birth weight under 2500 grams? *Refer to clinic for monitoring. Schedule further home visits*	.....	N		
c. Are there any children under 5 in the house whose immunisations are not up to date? *Refer for catch-up EPI at clinic*	.....	N		
d. Are there any children under 5 who have not had a dose of vitamin A in the last 6 months? *Refer for vitamin A supplement at clinic*	--------	N		
e. Are there any children who have not been weighed according to the growth-monitoring schedule or who show signs of malnutrition/growth faltering? *Refer for growth monitoring. Complete a nutritional assessment and schedule follow-up visits if needed*	.....	N		
f. Are there any children with suspected illness or does mother/caregiver have concerns about any child's current or recent health status? *Assess and refer to clinic if needed. Schedule follow-up visits*	.....	N		
g. Are there any HIV exposed children in the household 6 weeks or older who have not had a PCR test? *Check the RTHB. Refer to clinic for PCR test. Schedule follow-up visit*	---------	N		
h. If anyone in the HH is taking medication for the following, write their HH member number in the box(es) below. TB | HIV | Hypertension | Diabetes | Other *(Specify)*	.....	N		
i. Has someone defaulted from treatment? *Write HH member # of defaulter. Refer to clinic for further care and schedule follow-up visit for treatment adherence support.*	.....	N		
j. Any other problems identifi (state).				

Comments/Notes

* NOTE: It is expected that an Individual Health Record is complete for every client that is being followed in the household.

CHW Signature _____ Verifi by Team Leader _____ on _____ (date)

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