



This Sheet has to be filled on Admission by Doctor on Duty

MOTHER'S INFORMATION : Past History and ANC Period

Mother's Age Yrs.	Mother's WtKgs.	Age at Marriage.....Yrs.
Consanguinity : Yes [] No []	Birth Spacing: < 1 Yr / 1-2 Yr / >2-3 Yr / > 3 Yr / Not Applicable	
Gravida :.....	Para :.....	Live Birth :..... Abortion:
LMP :/...../.....	EDD :/...../.....	Gestation Weeks :
Antenatal Visit's : None / 1 / 2 / 3 / 4	T.T. Doses : None / 1 / 2	
Hb :	Blood Group :	
PIH : No [] Yes []	Hypertension / Pre Eclampsia / Eclampsia	
Drug : No [] Yes [] (.....)	Radiation : Yes [] No []	
Illness : Malaria / T.B. / Jaundice / Rash with Fever / U.T.I. / Syphilis/ Other (.....)		
APH : Yes [] No []	GDM : Yes [] No []	
Thyroid : Euthyroid (N) / Hypothyroid / Hyperthyroid / Not Known		
VDRL : Not Done / + Ve / -Ve	HbsAg : Not Done / + Ve / -Ve	
HIV Testing : Done / Not Done	Amniotic Fluid Volume : Adequate / Polyhydraminos / Oligohyd.	
Other Significant Information :		

MOTHER'S INFORMATION : During Labour

Antenatal Steroids : Yes [] No []	If Yes, Betamethasone [] / Dexamethasone []
No. of doses : [1] [2] [3] [4]	Time Between Last Dose & Delivery hrs./ Days
H/O Fever : In 1st Trimester / In 2nd Trimester / In 3rd Trimester / During Labor only if >100.4F	
Foul Smelling Discharge : Yes [] No []	Uterine Tenderness: Yes [] No []
Leaking P.V. > 24 Hours. : Yes [] No []	PIH : Hypertension / Pre Eclampsia / Eclampsia
PPH : Yes [] No []	
Amniotic Fluid : Clear / Blood Stained / Meconium Stained / Foul Smelling	
Presentation : Vertex / Breech / Transverse	Labour : Spontaneous / Induced
Course of Labour : Uneventful / Prolonged 1st stage / Prolonged 2nd stage / Obstructed	
E/O Feotal Distress : Yes [] No []	Type of Delivery : LSCS / AVD / NVD
Indication for Caesarean, if Applicable : [Cephalo Pelvic Disproportion] [Malpresentation] [Placenta Previa] [Obstructed Labor] [Foetal Distress] [Prolonged Labour] [Cord Prolapse] [Failed Induction (Dystocia)] [Previous LSCS] [Other]	
Delivery Attended by : [Doctor] [Nurse] [ANM] [Dai] [Relative] [Any Other].....	
Other Significant Information :	

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No []"

BABY'S INFORMATION: At Birth

Cried Immed. after Birth	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Wt. at Birth: Kgs.
Gestational age	: in completed weeks	Maturity : Preterm (<37 Wk) / Full term / Post term (≥42 Wk)
APGAR at 1 Min	: / Not Available	APGAR at 5 Min : / Not Available
Resuscitation Required	: NO [<input type="checkbox"/>] Yes [<input type="checkbox"/>] Tactile Stimulation / Only Oxygen / Bag & Mask [Duration.....min.]/ Intubation / Chest Compression / Adrenaline	
Vitamin K Given	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Breast Fed within 1 Hour : Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]

BABY'S INFORMATION : On Admission

PRESENTING COMPLAINTS:

GENERAL EXAMINATION

General Condition	: [Alert] [Lethargic] [Comatose]	Temperature°C	Heart Rate...../min
Apnea	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	RR/min.	B.P :
Grunting	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Chest Indrawing	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]
Head Circumference	:c.m.	Lengthc.m.
Color	: Pink / Pale / Central Cyanosis / Peripheral Cyanosis		
CRT >3 secs	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Skin pinch > 2 secs	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]
Meconium Stained Cord	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Cry	: Absent / Feeble / Normal / High Pitch
Tone	: Limp / Active / Increase Tone	Convulsions	: Present on Admission / Past History / No
Jaundice	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] If Yes, extent [Face] [Chest] [Abdomen] [Legs] [Palms / Soles]		
Bleeding	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] If Yes ,specify site [Skin] [Mouth] [Rectal] [Umbilicus]		
Bulging Anterior Fontanel	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]	Taking Breast Feeds	: Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]
Sucking	: [Good] [Poor] [No Sucking]	Attachment	: [Well attached] [Poorly attached] [Not attached]
Umbilicus	: [Red] [Discharge] [Normal]	Skin Pustules	: [No] [Yes <10] [Yes ≥10] [Abscess]
Congenital Malformation	: No [<input type="checkbox"/>] Yes [<input type="checkbox"/>] Diaphragmatic Hernia / Hydrocephalus / M.M.C. / Imperforate Anus / T.O. Fistula / Cong. Heart Disease / Cleft Palate / Cleft Lip / Cleft Palate with Cleft Lip / Cong. Deformity of Hip / Cong. Deformity of Feet / Other.....		
Blood Sugar	:	Oxygen Saturation	:
Other Significant Information :			

If Information is Not Available, Leave the Field Blank, Do Not ✓ “No [☐]”

SYSTEMIC EXAMINATION

CVS :
RESPIRATORY :
PER ABDOMEN :
CNS :
OTHER SIGNIFICANT FINDING :

TREATMENT ADVISED : On Admission

INVESTIGATIONS ADVISED : On Admission

Doctor's Name and Signature

सहमति पत्र

हमें डॉक्टर द्वारा बता दिया गया है कि हमारा शिशु गंभीर रूप से बीमार है एवं उपचार के दौरान होने वाली जटिलताओं से हमें अवगत करा दिया गया है तथा हमें पूर्ण रूप से विदित है कि उपचार के दौरान समस्याएँ उत्पन्न हो सकती हैं। इन सभी खतरों से अवगत होने के बाद भी हम हमारे बच्चे को एस.एन.सी.यू. जिला चिकित्सालय में उपचार हेतु भर्ती कराने के लिये सहमत हैं।

Foot Print of Newborn
(Left Foot)

अभिभावक के हस्ताक्षर

FINAL OUTCOME

Successfully Discharged / Left Against Medical Advice / Referred / Expired

In Case of Death : Mention Cause of Death (✓ The Most Relevant Single Indication)

- | | | |
|---|--|---------------------------|
| 1. Respiratory Distress Syndrome | 6. Meningitis | 11. Cause not established |
| 2. Meconium Aspiration Syndrome | 7. Major Congenital Malformation | 12. Any Other : |
| 3. HIE / Moderate-Severe Birth Asphyxia | 8. E.L.B.W. (Wt. less than 1000g) | |
| 4. Sepsis | 9. Prematurity (<28 weeks of Gestation) | |
| 5. Pneumonia | 10. Neonatal Tetanus | |

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