



This Card has to be filled on Discharge by Doctor on Duty

MOTHER'S INFORMATION : During Labour

(Put Same as in Case Record Sheet)

Antenatal Steroids : _____	Number of Doses : _____	Time Between Last Dose & Delivery : _____
Foul Smelling Discharge : _____	Uterine Tenderness : _____	Leaking P.V. > 24 Hours : _____
H/O Fever : _____	PPH : _____	PIH : _____
Amniotic Fluid : _____	Presentation : _____	Labor : _____
Course of Labor : _____	E/O Fetal Distress: _____	Type of Delivery : _____
Indication for Caesarean, if Applicable [_____]		Delivery Attended by : _____

BABY'S INFORMATION : At Birth

(Put Same as in Case Record Sheet)

Cried Immed. after Birth : _____	Wt. at Birth : _____ Kgs.	Gestational Age _____ (in completed weeks)
Maturity : _____	APGAR at 1 Min : _____	APGAR at 5 Min : _____
Resuscitation Required : _____	Vitamin K Given : _____	Breast Fed within 1 Hour : _____

BABY'S INFORMATION : On Admission

(Put Same as in Case Record Sheet)

GENERAL EXAMINATION

General Condition : _____	Temperature : _____ °C	Heart Rate : _____ /min	Apnea: _____	RR : _____ /min
B.P. : _____	Grunting : _____	Chest Indrawing : _____	Head Circumference : _____ c.m.	
Length : _____ c.m.	Color : _____	Cry : _____	CRT > 3 secs : _____	
Skin pinch > 2 secs : _____	Meconium Stained Cord : _____	Tone : _____	Convulsions : _____	
Jaundice : _____	Bleeding : _____	Bulging Anterior Fontanel : _____	Taking Breast Feed : _____	
Sucking : _____	Attachment : _____	Umbilicus : _____	Skin Pustules : _____	
Congenital Malformation : _____	Blood Sugar : _____	Oxygen Saturation : _____		

SYSTEMIC EXAMINATION

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

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TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Step-Down : Yes / No (If yes duration.....)
4. KMC : Yes / No (If yes duration.....)
5. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)
b)
c)
d)

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COURSE DURING TREATMENT

RELEVANT INVESTIGATIONS

CONDITION ON DISCHARGE

IMMUNIZATION STATUS

RI Card ☐ BCG ☐ OPV (0 Dose) ☐ Hepatitis B (Birth Dose) ☐

TREATMENT ADVISED ON DISCHARGE

1. Exclusive Breast Feeding till 6 months of Age.
2. Burp well after feed.
3. Maintain Temperature.
4. Immunization as per Schedule.
5. Follow-up as per Schedule.

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Doctor's Name and Signature

Institutional Follow up at S.N.C.U.

Visit	Anthropometry	Immunization Status	Examination Findings	Advice
<u>8 Days</u> Scheduled Date/...../20..... Date of Visit/...../20.....	Wt. (kg.) Total Length (cm.) Head Circumfer. (cm.)		General : Systemic :	Seen by.....
<u>1 Month</u> Scheduled Date/...../20..... Date of Visit/...../20.....	Wt. (kg.) Total Length (cm.) Head Circumfer. (cm.)		General : Vision : Hearing : Systemic :	Seen by.....
<u>3 Months</u> Scheduled Date/...../20..... Date of Visit/...../20.....	Wt. (kg.) Total Length (cm.) Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
<u>6 Months</u> Scheduled Date/...../20..... Date of Visit/...../20.....	Wt. (kg.) Total Length (cm.) Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
<u>1 Year</u> Scheduled Date/...../20..... Date of Visit/...../20.....	Wt. (kg.) Total Length (cm.) Head Circumfer. (cm.) M.U.A.C. (mm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....

This part has to be filled on follow-up by Doctor on Duty