#### BD - 1

Identification Number

**BIRTH DEFECTS NOTIFICATION FORM**

**Ministry of Health – Sri Lanka**

**A. BASIC INFORMATION**

1. Infant’s (Mother’s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Sex of Infant : 🞎 Male 🞎 Female 🞎 Ambiguous

3. Location where

Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ward / Unit \_\_\_\_\_\_\_\_\_\_\_\_ BHT No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

case identified:

4. Residential Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. MOH Division \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. District / RDHS :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. Maternal Age \_\_\_\_\_Yrs 9. Contact Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Ethnicity : 🞎 Sinhala 🞎 Tamil 🞎 Muslim 🞎 Burgher 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Date of Birth / Delivery : \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ 12. Place of Delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Date of Case Identified: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ 14. Age at case detection: \_\_\_\_\_ days \_\_\_\_months

15. Living Status: 🞎 Living 🞎 Still born 🞎 Neonatal Death 🞎 Post-Neonatal Death

16. Date of Death : \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ 17. Post mortem / Necropsy details: 🞎 Done 🞎 Not done

**B. Description of the congenital abnormalities**

Presence of congenital abnormalities: 🖵 Isolated 🖵 Multiple 🖵 Syndromic

*Description of the congenital abnormalities:*

**J. DEATH DETAILS**

|  |
| --- |
| Date of Death: \_\_\_/\_\_\_/\_\_\_\_\_ Age at Death: \_\_\_\_\_Yrs \_\_\_\_Mths\_\_\_\_\_days Place of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Cause/s of Death:** Underlying Cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immediate Cause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Conditions contributing to Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Signature of the Informant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name & Designation :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of the Head of Institution Name :**

**Stamp: Date :**

*Please prepare this report in duplicate and fax/send one copy to* ***Director / Family Health Bureau, 231 De Saram Place, Colombo 10*** *(Fax Nos: 0112690790/ 0112692745) AND keep the remaining copy for official purposes at your institution.*