FORM 4b:
FACILITY BASED POST-NEONATAL DEATH REVIEW FORM

For Office Use Only:

FBCDR NO:	Year

Name & Address of the facility where death occurred: .....
(Including State, District, Block): .....

Instructions

1. *NOTE: This form must be completed for all post - neonatal deaths (29 days to 5 years) occurring in the hospital.*
2. *Complete the form in duplicate within 48 hours of the newborn death. The original remains at the institution where the death occurred and one copy is sent to the DNO within one month.*
3. *Write in capital letters*
4. *Circle the appropriate response (or) place a √ (tick) wherever applicable*
5. *Attach a copy of the case records to this form.*

Section A: Details of Deceased		
1.	Inpatient Number/ID	
2.	Age	☐ Years ☐☐ (in completed months)
3.	Sex	☐ Male ☐ Female
4.	Category SC/ST ☐	OBC ☐ General ☐
5.	Name of the child	
6.	Name of the Mother	
7.	Address (including Block/Tehsil, District/Taluq/Division, State)	
8.	Date of birth	D D / M M / Y Y Y Y
9.	Place of birth	☐ Health facility ☐ Home ☐ Transit
10.	Birth weight (if available on record)	☐☐.☐☐ kgs.
11.	Date of admission	D D / M M / Y Y Y Y
12.	Time of admission	____:____ AM/PM
13.	Date of death	D D / M M / Y Y Y Y
14.	Time of death	____:____ AM/PM
15.	Death certified by : **(Name & Designation of the Doctor)**	

16.	At any time child was admitted to NRC ☐ Yes ☐ No		
17.	Growth Curve (fill for child less than 3 years; check MCP card):		
a. Green zone ☐	b. Yellow Zone ☐	c. Orange Zone ☐	
18.	Type of facility where death took place		
a.	CHC / FRU / RH ☐		
b.	Sub district hospital/Taluq hospital ☐		
c.	District Hospital ☐		
d.	Medical college/tertiary hospital ☐		
19.	Main complaints at the time of admission		If Yes, Duration of symptoms
a.	Inability to feed	Y/N	☐☐ days
b.	Fever	Y/N	☐☐ days
c.	Loose stools	Y/N	☐☐ days
d.	Vomiting	Y/N	☐☐ days
e.	Cough or difficult breathing	Y/N	☐☐ days
f.	Convulsions	Y/N	☐☐ days
g.	Lethargic or unconscious	Y/N	☐☐ days
h.	Appearance of Skin rashes	Y/N	☐☐ days
i.	Bleeding	Y/N	☐☐ days
j.	Injury (like fractures, wounds)	Y/N	☐☐ days
k.	Corneal ulcer	Y/N	☐☐ days
l.	Stunted growth	Y/N	☐☐ days
m.	Severe muscle wasting	Y/N	☐☐ days
n.	Oedema of both hand & feet	Y/N	☐☐ days
o..	Unknown bites or stings Any other symptom	Y/N	☐☐ days
p.	Any other symptom (if yes specify _____)	Y/N	☐☐ days
20.	Weight of child on admission: ☐☐.☐☐ kgs.		
21.	Height at the time of admission : ☐☐☐ Cms		
22.	Immunisation history of child: BCG ☐ DPT1 ☐ DPT 2 ☐ DPT 3 ☐ OPV1 ☐ OPV2 ☐ OPV3 ☐ Hepatitis B birth dose ☐ Hepatitis B 1st dose ☐ Hepatitis B 2nd dose ☐ Measles ☐ Measles Booster ☐ Hib 1st dose ☐ Hib 2nd dose ☐		

Section B: Condition on Admission					
23.	Breathing status of child at the time of admission				
a.	Normal breathing ☐				
b.	Severe chest in drawing ☐				
c.	Central cyanosis ☐				
d.	Gasping ☐				
e.	Not breathing ☐				
24.	Consciousness level of child at the time of admission				
a.	Stable ☐				
b.	Convulsions ☐				
c.	Semi-conscious, responds to verbal commands ☐				
d.	Semi-conscious, responds to painful stimuli ☐				
e.	Unconscious ☐				
25.	Circulation status of child at the time of admission				
a.	Capillary refill time ☐ < 3 seconds ☐ > 3 seconds				
b.	Extremities: ☐ warm to touch and colder than the abdomen				
c.	Pulse: ☐ Not palpable ☐ Weak pulse ☐ fast pulse				
26.	Did child have any other symptoms				
a.	Dehydration ☐		b.	Bleeding ☐	
c.	Icterus ☐		d.	Petechial rashes or bruising ☐	
e.	Trauma/other surgical condition ☐		f.	Burns ☐	
g.	Oedema of both feet ☐		h.	Severe wasting ☐	
i.	Ear discharge ☐		j.	Severe cyanosis ☐	
27.	Duration of stay in the health facility ☐ <48 hours ☐ 48 hours -7 days ☐ 8-14 days ☐ 14-21 days ☐ More than 21 days				
28.	Investigations done		Note down the results		
a.	Blood glucose	Y/N			
b.	CBC	Y/N			
c.	Urine test	Y/N			
d.	Renal function tests	Y/N			
e.	CSF	Y/N			
f.	Widal test	Y/N			
g.	Serum bilirubin	Y/N			
h.	Blood culture	Y/N			
i.	Liver Function Test	Y/N			
j.	Urine culture	Y/N			
k.	Others (specify.....)	Y/N			

Section C: Referral Details			
29.	Was the child referred from another Centre?	☐ Yes ☐ No ☐ DNK **(if no or DNK, go to Section D)**	
30.	If yes (to any of the questions above), type of facility from which last referred?	a.	24x7PHC ☐
		b.	SDH/Rural Hospital/CHC ☐
		c.	District Hospital ☐
		d.	Private Hospital ☐
		e.	Private clinic ☐
		f.	Others (specify.....) ☐
31.	Have multiple referrals been made? (include both private and public health facilities)	☐ Yes ☐ No ☐ DNK **(if no or DNK, go to Section D)**	
32.	If yes, how many?	☐ One, ☐ Two ☐ Three ☐ Four ☐ More Than 4	

Section D: Treatment Details			
33.	Details of treatment given in the hospital		
a.	Resuscitation	☐ Yes	☐ No
b.	Oxygen use	☐ Yes	☐ No
c.	IV Fluids **Provide details:**	☐ Yes	☐ No
d.	Antibiotics	☐ Yes	☐ No
e.	Anticonvulsants	☐ Yes	☐ No
f.	Bronchodilators	☐ Yes	☐ No
g.	Blood Components **Provide details:**	☐ Yes	☐ No
h.	Steroids	☐ Yes	☐ No
i.	Antituvercular drugs	☐ Yes	☐ No
j.	Antiretroviral drugs	☐ Yes	☐ No
k.	Vasopressors (Dopamine, dobutamine, adrenaline)	☐ Yes	☐ No
l.	Respiratory support (CPAP/Ventilator)	☐ Yes	☐ No
m.	Surgical interventions **Provide details:**	☐ Yes	☐ No
n.	Other interventions **Provide details:**	☐ Yes	☐ No

Section E: Diagnosis	
34.	Provisional diagnosis at time of admission
35.	Provisional diagnosis at time of death **(Immediately at the time of death, by the Medical Officer on duty)**
36.	Probable direct cause of death
37.	Indirect cause of death
38.	Final Diagnosis (Within one week) **(Final Diagnosis by the treating doctor)**

Signature of the certifying doctor

Name: .....
Designation: .....
Stamp & Date: .....

Signature of the treating doctor

Name: .....
Designation: .....
Stamp & Date: .....

Verified by Facility Nodal Officer/Administrative in charge of the Hospital:

Signature: .....
Name: .....

Designation: .....
Stamp and Date: .....