FORM 4a:
FACILITY BASED 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 new born deaths (upto 28 days) 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.

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

16.	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		☐
17.	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.	Fast breathing	Y/N	☐☐ days
f.	Convulsions	Y/N	☐☐ days
g.	Appearance of Skin rashes	Y/N	☐☐ days
h.	Injury (like fractures, wounds)	Y/N	☐☐ days
i.	Lethargy	Y/N	☐☐ days
j.	Stiffness of neck	Y/N	☐☐ days
k.	Bluish discolouration of lips, nails	Y/N	☐☐ days
l.	Skin pustules of yellowish colour	Y/N	☐☐ days
m.	Any other symptom (if yes specify _____)	Y/N	☐☐ days
18.	Weight of child on admission: ☐☐.☐☐ kgs.		
19.	Immunisation history of child: BCG ☐ OPV Birth Dose ☐ Hepatitis B birth dose ☐		
	Section B: Condition on Admission		
20.	Breathing status of child at the time of admission		
a.	Normal breathing		☐
b.	Severe chest in drawing		☐
c.	Apnoeic episodes		☐
d.	Central cyanosis		☐
e.	Gasping		☐
f.	Not breathing		☐
21.	Consciousness level of child at the time of admission		
a.	Alert, responds to normal stimuli		☐
b.	Semi-conscious, responds to painful stimuli		☐
c.	High pitched cry or Persistent crying		☐

d.	Lethargic	☐			
e.	Inability to suck	☐			
f.	Unconscious	☐			
22.	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				
23.	Did baby have any other symptoms				
a.	Dehydration	☐	b.	Bleeding	☐
c.	Icterus	☐	d.	Petechial rashes or bruising	☐
e.	Trauma/other surgical condition	☐	f.	Congenital malformation	☐
g.	Bulging fontanelle	☐	h.	Hypothermia	☐
i.	Hyperthermia	☐	j.	Sclerema	☐
24.	Duration of stay in the health facility ☐ <48 hours ☐ 48 hours -7 days ☐ 8-14 days ☐ 14-21 days ☐ More than 21 days				

25.	Investigations done		Note down the results
a.	Blood glucose	Y/N	
b.	CBC	Y/N	
c.	Sepsis screen	Y/N	
d.	CRP	Y/N	
e.	Renal function tests	Y/N	
f.	Liver function tests	Y/N	
g.	CSF	Y/N	
h.	S. Bilirubin	Y/N	
i.	Others (Please specify): _____	Y/N	

Section C: Referral Details

26.	Was the child referred from another Centre?	☐ Yes ☐ No ☐ DNK **(if no or DNK, go to Section D)**	
27.	If yes, 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.....) ☐
28.	Have multiple referrals been made? (include both private and public health facilities)	☐ Yes ☐ No ☐ DNK **(if no or DNK, go to section D)**	

29.	If yes, how many?	☐ One, ☐ Two ☐ Three ☐ Four ☐ More Than 4

Section D: Intrapartum and Postpartum Details (only for inborn babies)		
Instruction: To be filled for inborn babies only otherwise go to Section - E		
30.	Was the onset of labour	☐ Spontaneous ☐ Induced ☐ DNK
31.	What was the Gestational age at the time of admission	☐ Term (> 37–<42 weeks) ☐ Preterm (☐ < 28 weeks; ☐ 28–<32 weeks; ☐ 32–<37 weeks) ☐ Post term (> 42 weeks)
32.	What was the Mode of Delivery	☐ Spontaneous Vaginal (with/without episiotomy) ☐ Vacuum/forceps ☐ Caesarean section
33.	Were there any complications during labour?	☐ PROM ☐ Sepsis ☐ Eclampsia ☐ Obstructed labour/Rupture Uterus ☐ Others Specify.....
34.	Was Partograph used?	☐ Yes ☐ No ☐ DNK
35.	Birth weight	☐☐.☐☐ kgs
36.	Was the resuscitation at birth done	☐ Yes ☐ No ☐ DNK **(if No or DNK, go to Q 37)**
37.	If Yes, Who gave resuscitation?	☐ Obstetrician ☐ Paediatrician ☐ MBBS doctor/other specialist ☐ Staff Nurse ☐ Others (specify)
38.	APGAR Score (if recorded at time of birth)	

Section E: Treatment Details			
39.	Details of treatment given in the hospital		
a.	Resuscitation	☐ Yes	☐ No
b.	Temperature Control (in case of newborns only)	☐ Yes	☐ No
c.	Phototherapy	☐ Yes	☐ No
d.	Oxygen use	☐ Yes	☐ No
e.	IV Fluids **Provide details:**	☐ Yes	☐ No
f.	Antibiotics	☐ Yes	☐ No

g.	Anticonvulsants	☐ Yes	☐ No
h.	Bronchodilators	☐ Yes	☐ No
i.	Blood Components **Provide details:**	☐ Yes	☐ No
j.	Steroids	☐ Yes	☐ No
k.	Antiretroviral drugs	☐ Yes	☐ No
l.	Vasopressors (Dopamine, dobutamine, vasopressors)	☐ Yes	☐ No
m.	Exchange Blood transfusion	☐ Yes	☐ No
n.	Respiratory support (CPAP/Ventilator)	☐ Yes	☐ No
o.	Surgical interventions **Provide details:**	☐ Yes	☐ No
p.	Other interventions **Provide details:**	☐ Yes	☐ No

Section F: Diagnosis		
40.	Please tick against the appropriate option:	
a.	Death was within 24 hours of birth	☐
b.	Death was in first week (day 2-7 days)	☐
c.	Death was in the late neonatal period (8-28 days)	☐
41.	Provisional diagnosis at time of admission	
42.	Provisional diagnosis at time of death **(immediately at the time of death, by the Medical Officer on duty)**	
43.	Probable direct cause of death	
44	Indirect cause of death	
45.	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: .....