FORM 2:
FIRST BRIEF INVESTIGATION REPORT

Instructions:

1. *To be filled by the ANM*
2. *Write in capital letters*
3. *Circle the appropriate response (or) place a √ (tick) wherever applicable*

Section A. Background Information

1. Name of the Child : _____
2. Date of Birth (if available) D D / M M / Y Y Y Y
3. Age: ☐ Years ☐☐ Months ☐☐ Days (if age less than 1 month)
   ☐☐ Hours (if age less than one day)
4. Sex: ☐ Male ☐ Female
5. Address: _____
6. Name of Area PHC _____
7. Name of Area Sub-center _____
8. Order of Birth: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
9. Belongs to: SC/ ST ☐ OBC ☐ General ☐
10. Does the family have a Below Poverty Line (BPL) card: Yes ☐ No ☐
11. Immunization Status:

    BCG ☐ DPT 1 ☐ DPT 2 ☐ DPT 3 ☐ Measles ☐ Measles Booster ☐

    HiB 1 ☐ HiB 2 ☐ HiB 3 ☐
12. Weight (if recorded in the MCP card): ☐☐ . ☐☐ Kg
13. Growth Curve (fill for child less than 3 years; check MCP card):

    a. Green zone ☐ b. Yellow Zone ☐ c. Orange Zone ☐
14. Any h/o illness/injury: Yes ☐ No ☐ **(if No, go to Sec. B)**
15. If yes, nature of illness: ☐

16.	Symptoms during illness	Circle the app. response	If Yes,Duration of symptoms
a.	Inability to feed	Yes/No	☐☐ days
b.	Fever	Yes/No	☐☐ days
c.	Loose stools	Yes/No	☐☐ days
d.	Vomiting	Yes/No	☐☐ days
e.	Fast breathing	Yes/No	☐☐ days
f.	Convulsions	Yes/No	☐☐ days
g.	Appearance of Skin rashes	Yes/No	☐☐ days
h.	Injury (like fractures, wounds)	Yes/No	☐☐ days
i.	Any other symptom (if yes) specify	Yes/No	☐☐ days

17. Details of treatment:

1) Whether treatment for illness was taken or not? Yes ☐ No ☐ **(if No, go to sec. B)**

2) If yes, where was the child treated:

a. Public Health Facility: PHC ☐ CHC ☐ DH ☐ SDH/Taluq Hospital ☐

b. Private Hospital/Nursing Home ☐

c. Qualified allopathic private practitioner ☐

d. AYUSH practitioner ☐

e. Unqualified provider (quack, informal provider) ☐

f. Traditional healer ☐

Section B. Probable cause of death:

a. Diarrhoea ☐ b. Pneumonia ☐ c. Malaria ☐

d. Measles ☐ e. Septicemia (Infection) ☐ f. Meningitis ☐

g. Injury ☐ h. Any other cause (specify) ..... ☐

i. No identifiable cause ☐

Section C. According to the respondent (parent, close family member), what was the cause of death?

Section D. At which level do you think the delay occurred?

1. **Delay at home** (eg; seriousness of illness not recognized, treatment not sought, treatment sought at a late stage, family members did not allow treatment seeking) ☐
2. **Delay in transportation** (eg; transport facility not available, could not afford local transport, difficult/hilly terrain, long distance to the health facility) ☐
3. **Delay at facility level** (eg; doctor/staff not available, drugs & equipment not available, delay in initiation of treatment) ☐

Section E. Based on your analysis of the situation in which the death took place, what according to you could have been done to avert this death?

1. _____
2. _____
3. _____

Name of ANM..... **Signature**.....

Health Centre..... **Date**.....