**1. IDENTITAS**

FOTO IBU

|  |  |  |
| --- | --- | --- |
|  | IBU | SUAMI / KELUARGA |
| NAMA |  |  |
| NIK |  |  |
| PEMBAYARAN |  |  |
| NO. JKN:  FASKES TK 1:  FASKES RUJUKAN: |  |  |
| GOL. DARAH |  |  |
| TEMPAT  TANGGAL LAHIR |  |  |
| PENDIDIKAN |  |  |
| PEKERJAAN |  |  |
| ALAMAT RUMAH |  |  |
| TELEPON |  |  |
| PUSKESMAS DOMISILI:  NO. REGISTER KOHORT IBU: | | |

**Ibu menulis tanggal, tempat pelayanan; dan**

**2. PERNYATAAN IBU KELUARGA TENTANG PELAYANAN KESEHATAN IBU YANG SUDAH DITERIMA**

**tenaga kesehatan membubuhkan paraf sesuai jenis pelayanan**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ibu Hamil  HPHT: | | | Trimester I | | | | | | Trimester II | | | Trimester III | | | | | | | | | | |
| Periksa | | | Periksa | | | Periksa | | | Periksa | | | | Periksa | | | | Periksa | | |
| BB: | TB: | IMT: |
| Timbang | | |  | | |  | | |  | | |  | | | |  | | | |  | | |
| Ukur Lingkar Lengan Atas | | |  | | |  | | |  | | |  | | | |  | | | |  | | |
| Tekanan Darah | | |  | | |  | | |  | | |  | | | |  | | | |  | | |
| Periksa Tinggi Rahim | | |  | | |  | | |  | | |  | | | |  | | | |  | | |
| Periksa Letak dan Denyut  Jantung Janin | | |  | | |  | | |  | | |  | | | |  | | | |  | | |
| Status dan Imunisasi Tetanus | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Konseling | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Skrining Dokter | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Tablet Tambah Darah | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Test Lab Hemoglobin (Hb) | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Test Golongan Darah | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Test Lab Protein Urine | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Test Lab Gula Darah | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| PPIA | | |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |
| Tata Laksana Kasus | | |  | | |  | | |  | | |  | | |  | | | | |  | | |
| Ibu Bersalin  TP: | | | Fasilitas Kesehata: | | | | | | Rujukan: | | | | | |  | | | | | | | |
| Inisiasi Menyusui Dini | | |  | | | | | | | | | | | | | | | | | | | |
| Ibu Nifas  sampai 42 hari setelah  bersalin | | | KF 1 (6-48 jam) | | | | | KF 2 (3-7 hari) | | | | KF 3 (8-28 hari) | | | | | | KF 4 (28-42 hari) | | | | |
| Periksa Payudara (ASI) | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Periksa Perdarahan | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Periksa Jalan Lahir | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Vitamin A | | |  | | | | |  | | | |  | | | | | |  | | | | |
| KB Pasca Persalinan | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Konseling | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Tata Laksana Kasus | | |  | | | | |  | | | |  | | | | | |  | | | | |
| Bayi baru lahir / neonates  0-28 hari | | | KN 1 (6-48 jam) | | | | | KN 2 (3-7 hari) | | | | KN 3 (8-28 hari) | | | | | |  | | | | |
| Pastikan pelayanan kesehatan neonatus dicatatkan di bagian anak | | | | | | | | | | | | | | | | | | | |

**MENYAMBUT**

**3. AMANAT PERSALINAN**

**PERSALINAN**

(Agar Aman dan Selamat)

Saya : …………………………………………………………………………………

Alamat : …………………………………………………………………………………

Memberikan kepercayaan kepada nama-nama ini untuk membantu persalinan saya agar aman

dan selamat, yang diperkirakan pada, Bulan: ………………….. Tahun: ……………………..

Penolong persalinan:

1. Dokter/Bidan: ………………………………………………………
2. Dokter/Bidan: ………………………………………………………

Untuk Dana Persalinan, disiapkan sendiri/ditanggung JKN/JAMPERSAL dibantu oleh:

…………………………………………………………………………..

Untuk kendaraan/ ambulan desa oleh:

1. ………………………………… HP ………………………………
2. ………………………………… HP ………………………………
3. ………………………………… HP ………………………………

Metode kontrasepsi setelah melahirkan yang dipilih:

…………………………………………………………………………..

Untuk sumbangan darah (golongan darah: ……… rhesus: …………..)

dibantu oleh:

1. ………………………………… HP ………………………………
2. ………………………………… HP ………………………………
3. ………………………………… HP ………………………………
4. ………………………………… HP ………………………………

Bersedia dirujuk jika memiliki faktor risiko/ komplikasi/ kegawatdarutan

………………….……20….

Ibu Hamil

(………………………………)

Persetujuan,

Suami/ Orang Tua/ Keluarga

(………………………………)

Bidan/Dokter

(………………………………)

Nama Dokter : ……………………………..

**4.1. PELAYANAN DOKTER**

Faskes : ……..………………………

**EVALUASI KESEHATAN IBU HAMIL**

**Status Imunisasi TT**

|  |  |  |  |
| --- | --- | --- | --- |
| TT  ke- | selang waktu | perlindungan | √ |
| 1 |  | awal |  |
| 2 | 1 bulan | 3 tahun |  |
| 3 | 6 bulan | 5 tahun |  |
| 4 | 12 bulan | 10 tahun |  |
| 5 | 12 bulan | >25 tahun |  |

Kesimpulan: Status imunisasi

Riwayat Perilaku Berisiko 1 Bulan sebelum hamil

|  |  |  |
| --- | --- | --- |
| merokok | pola makan berisiko | aktivitas fisik kurang |
| alkohol | Obat-obatan | kosmetik |

Lingkari pilihan yang sesuai

Lain-lain, jelaskan ………………………………...

……………………………………………………..

**Kondisi Kesehatan Ibu**

Tanggal periksa:

|  |  |  |
| --- | --- | --- |
| TB | cm | IMT% |
| BB | kg |
| Lila | cm |

**Riwayat Kesehatan Ibu Sekarang**

|  |  |
| --- | --- |
| Hipertensi | Asma |
| Jantung | TB |
| Typoid | Hepatitis B |
| Alergi | Jiwa |
| Autoimun | Sifilis |
| Diabetes |  |
| Lainnya: | ……………………… |

Lingkari pilihan yang sesuai

**Riwayat Kehamilan dan Persalinan (termasuk Keguguran, Kembar, dan Lahir Mati)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No** | **Tahun** | **berat lahir**  **(gram)** | **persalinan** | **penolong persalinan** | **komplikasi** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Lain-lain, jelaskan ……………………

………………………………………...………………………………………...………………………………………...

**Riwayat Penyakit Keluarga**

|  |  |  |
| --- | --- | --- |
| Hipertensi | Diabetes | Sesak Nafas |
| Jantung | TB | Alergi |
| Jiwa | Kelainan Darah | Hepatitis B |

Lingkari pilihan yang sesuai

**Pemeriksaan Khusus**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Inspeksi/  Inspekulo | Vulva | normal | | tidak normal |
| Uretra | normal | | tidak normal |
| Vagina | normal | | tidak normal |
| Fluksus +/-- | | Flour +/-- | |
| Porsio | normal | | tidak normal |

**Pemeriksaan Dokter Trimester 1 (Usia kehamilan <12 minggu)**

**4.2. PELAYANAN DOKTER**

(Konsep: Anamnesa dan pemeriksaan dokter umum mengenai risiko kehamilan saat ini normal/ kehamilan berkomplikasi)

**Pemeriksaan Fisik**

Keadaan Umum: ………………………….

|  |  |  |  |
| --- | --- | --- | --- |
| Konjuctiva | | normal | tidak |
| Sklera | | normal | tidak normal |
| Kulit | | normal | tidak normal |
| Leher | | normal | tidak normal |
| Gigi mulut | | normal | tidak normal |
| THT | | normal | tidak normal |
| Dada | Jantung | normal | tidak normal |
|  | Paru | normal | tidak normal |
| Perut | | normal | tidak normal | |
| Tungkai | | normal | tidak normal | |

**USG Trimester I**

HPHT : ……, Kehamilan …….. minggu

|  |  |
| --- | --- |
| GS (Gestational Sac) | cm |
| CRL (Crown-rump Length | cm |
| DJJ (Detak Jantung Janin) | dpm |
| Sesuai usia kehamilan | minggu |
| Letak janin | intrauterine/  ekstrauterin |
| Taksiran Persalinan |  |

Hasil USG

Pemeriksaan Laboratorium ( tanggal ….. / ….. / 20…. )

|  |  |  |
| --- | --- | --- |
| **Pemeriksaan** | **Hasil** | **Rencana Tindak Lanjut** |
| Hemoglobin | gr/dL |  |
| Golongan darah & Rhesus |  |  |
| Gula darah sewaktu | mg/dL |  |
| PPIA |  |  |
| * H | R/NR |  |
| * S | R/NR |  |
| * Hepatitis B | R/NR |  |
| * Lain-lain |  |  |

Kesimpulan : ………………………………………………………………………………...

Rekomendasi : ………………………………………………………………………………...

(ANC dapat dilakukan di FKTP atau rujuk ke FKRTL)

**Skrining Preeklampsia pada usia kehamilan < 20 minggu**

**4.3. PELAYANAN DOKTER**

|  |  |  |
| --- | --- | --- |
| **Kriteria** | **Risiko sedang** | **Risiko tinggi** |
| Anamnesis |  |  |
| Multipara dengan kehamilan |  |  |
| Kehamilan dengan teknologi reproduksi berbantu: bayi tabung, obat induksi ovulasi |  |
| Umur ≥ 35 tahun |  |
| Nulipara |  |
| Multipara yang jarak kehamilan sebelumnya > 10 tahun |  |
| Riwayat preeklampsia pada ibu atau saudara perempuan |  |
| Obesitas sebelum hamil (IMT > 30 kg/m2) |  |
| Multipara dengan riwayat preeklampsia sebelumnya |  |  |
| Kehamilan multiple |  |
| Diabetes dalam kehamilan |  |
| Hipertensi kronik |  |
| Penyakit ginjal |  |
| Penyakit autoimun, SLE |  |
| Anti phospholipid syndrome\* |  |
| Pemeriksaan Fisik |  |  |
| Mean Arterial Presure > 90 mmHg\*\* |  |  |
| Proteinuria (urin celup > +1 pada 2 kali pemeriksaan berjarak 6 jam atau segera kuantitatif 300 mg/24 jam) |  |
| Keterangan Sistem Skoring:  Ibu hamil dilakukan rujukan bila ditemukan sedikitnya   * 2 risiko sedang dan atau * 1 risiko tinggi   *\* Manifetasi klinis APS antara lain : keguguran berulang, IUFD, kelahiran premature*  *\*\* MAP dihitung setiap kali kunjungan ANC* | | |

*Cetang pilihan yang sesuai*

Kesimpulan : …………………………………………………………………………..

*Bilamana ibu berisiko preeklamsi maka pemeriksaan kehamilan, persalinan dan pemeriksaan nifas dilaksanakan di Rumah Sakit.*

*Lakukan rujukan terencana pada ibu hamil dengan kondisi yang disebutkan di atas (tidak perlu menunggu inpartu)*

Dokter Pemeriksa,

(………………………………)

**Lembar Pemeriksaan Dokter Trimester 3**

**4.4. PELAYANAN DOKTER**

**(Usia Kehamilan 32-36 minggu)**

**Pemeriksaan Fisik**

Keadaan umum: …………………………..

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Keadaan Umum** | **baik** | **sedang** | **buruk** |  |
| Konjunctiva | | anemia | tidak anemia |  |
| Sklera | | ikterik | tidak ikterik |  |
| Leher | | normal | tdk normal |  |
| Gigi mulut | | normal | tdk normal |  |
| THT | | normal | tdk normal |  |
| Dada | Jantung | normal | tdk normal |  |
| Paru | normal | tdk normal |  |
| Perut |  | normal | tdk normal |  |
| Tungkai |  | normal | tdk normal |  |

**USG Trimester III**

HPHT : ………., Kehamilan …………. Minggu

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Janin | Hidup / Tidak Hidup | | BPD | Cm |
| Jumlah janin | Tunggal / Ganda | | HC | Cm |
| Letak janin | Intrauterine | ekstrauterine | AC | Cm |
|  | Presentasi kepala  Presentasi sungsang  Presentasi melintang |  |
| Berat janin | gram | | FL | Cm |
| Plasenta | Normal / Tidak | | Cairan Ketuban | Cm |
| Usia kehamilan |  | |  |  |

Lingkari pilihan yang sesuai

**Pemeriksaan laboratorium** (tanggal ….. / ….. / 20… )

|  |  |  |
| --- | --- | --- |
| Pemeriksaan | Hasil | rencana tindak lanjut |
| Hemoglobin | gr/dL |  |
| Gula darah puasa |  |  |
| Gula darah 2 jam post prandial | mg/dL |  |

**Rencana Konsultasi Lanjut:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Gizi | Kebidanan | Anak | Penyakit Dalam | Neurologi | THT | Psikiatri | Lain-lain |

**Rencana Persalinan**

|  |  |  |  |
| --- | --- | --- | --- |
| Persalinan normal | Persalinan pervaginam | Section caesaria | Berbantu |

**Pilihan Rencana Kontrasepsi**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MAL** | **Pil** | **Suntik** | **AKDR** | **Implan** | **Steril** | **Belum memilih** |

MAL= Metode Amenore Laktasi AKDR= Alat Kontrasepsi Dalam Rahin

**Konseling**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Kebutuhan Konseling | tidak | ya |  |  |  |  |

Jelaskan : …………………………………………………………………………………

Lingkari pilihan yang sesuai

Kesimpulan : …………………………………………………………………………………

Rekomendasi : …………………………………………………………………………………

(Persalinan dapat dilakukan di FKTP atau Rujuk ke FKRTL)

**GRAFIK EVALUASI KEHAMILAN**

**5.1. PELAYANAN KEHAMILAN**

**Diisi oleh Bidan atau Perawat**

**20**

**18**

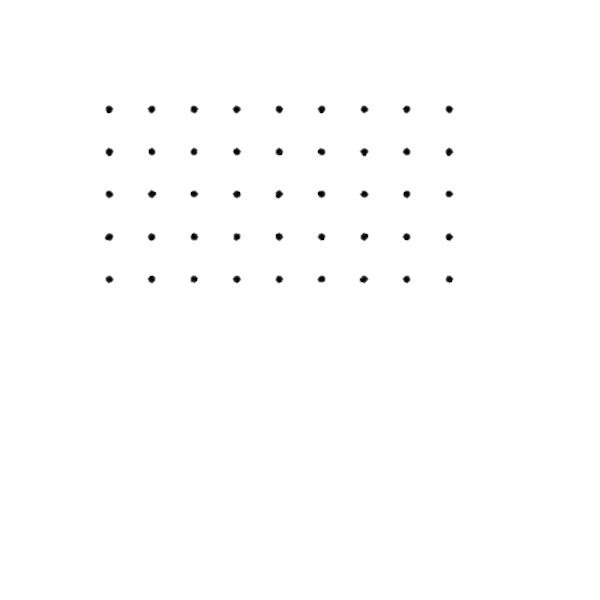
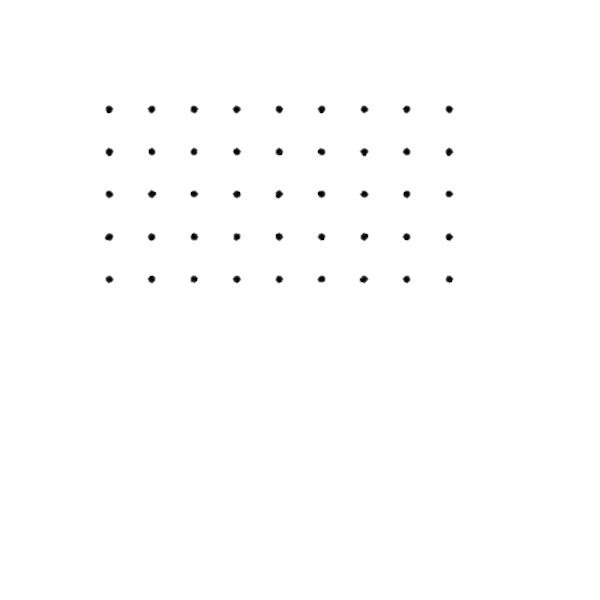
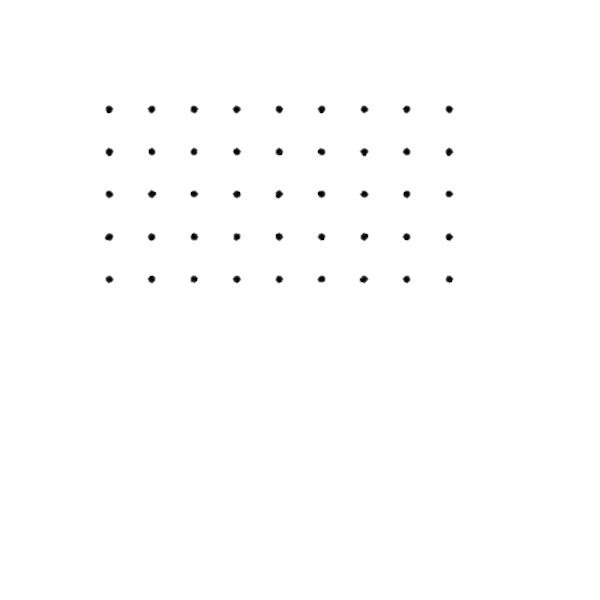
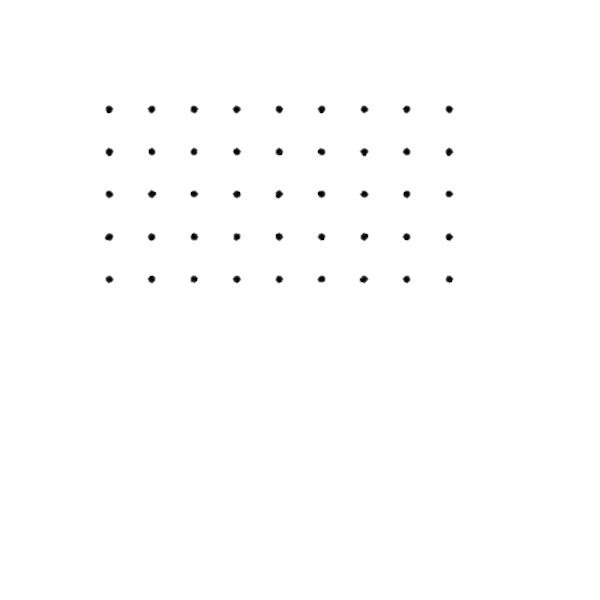
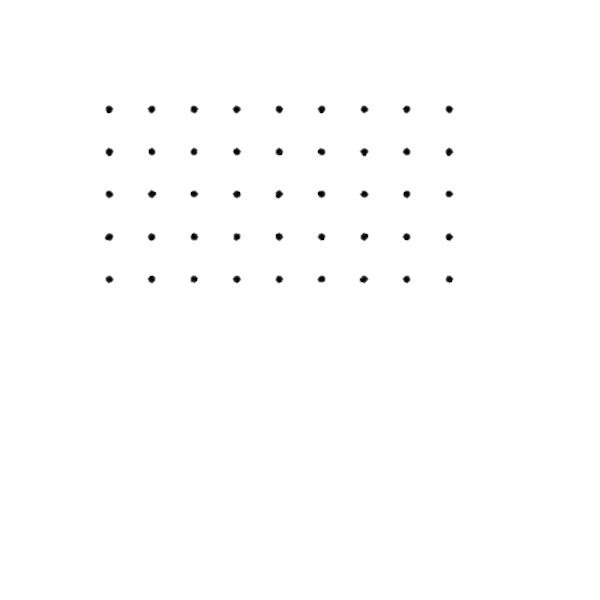
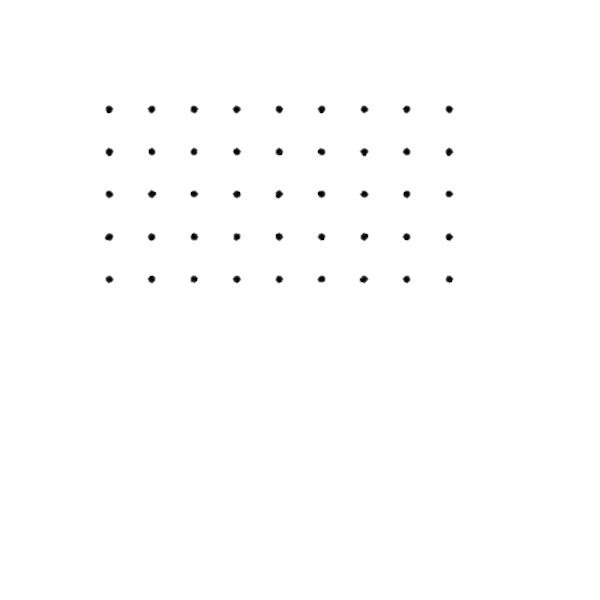
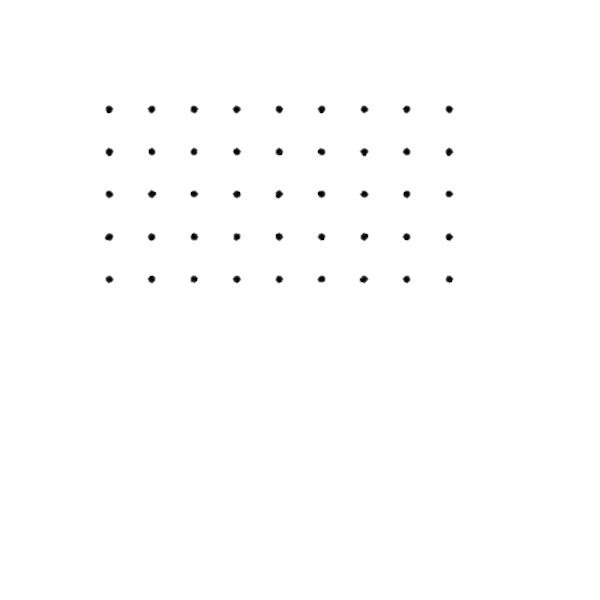
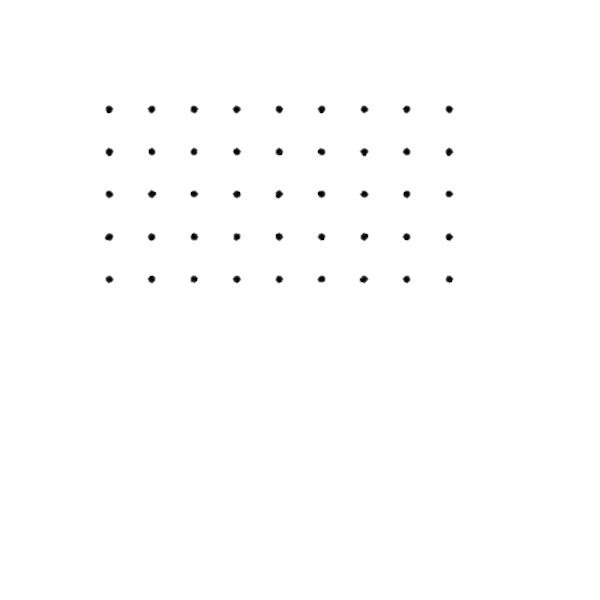
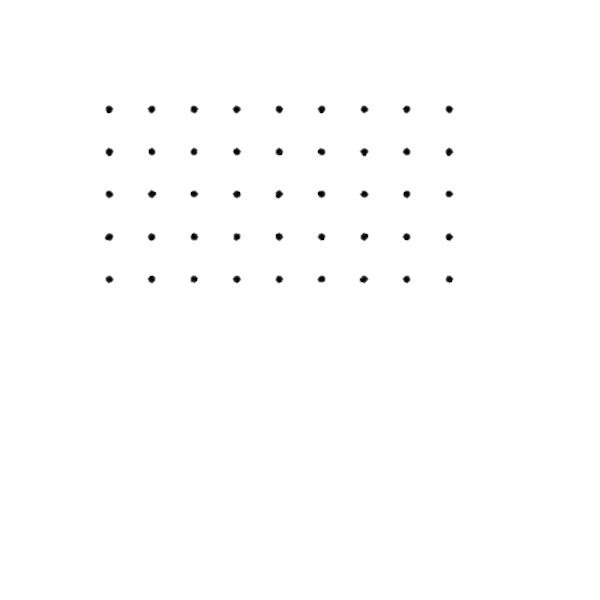
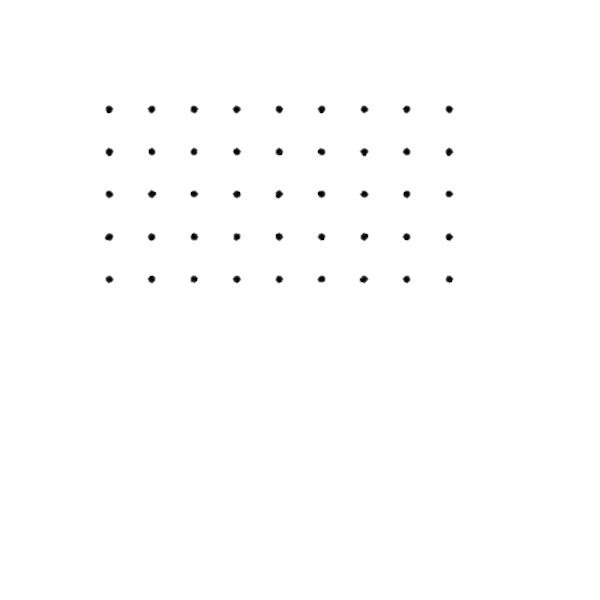
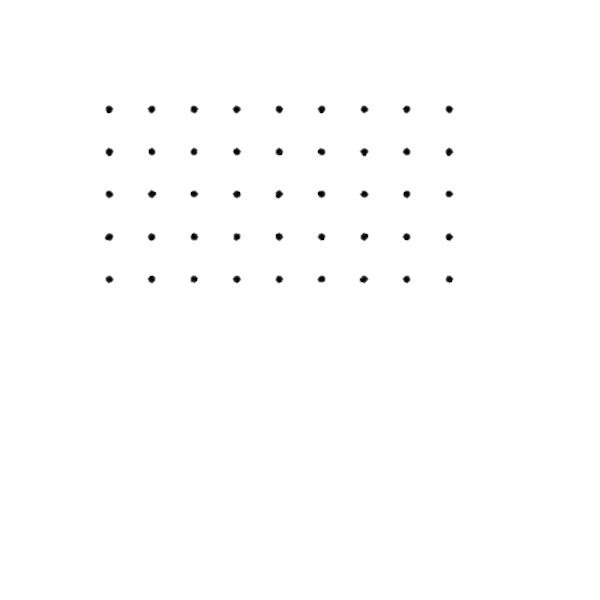
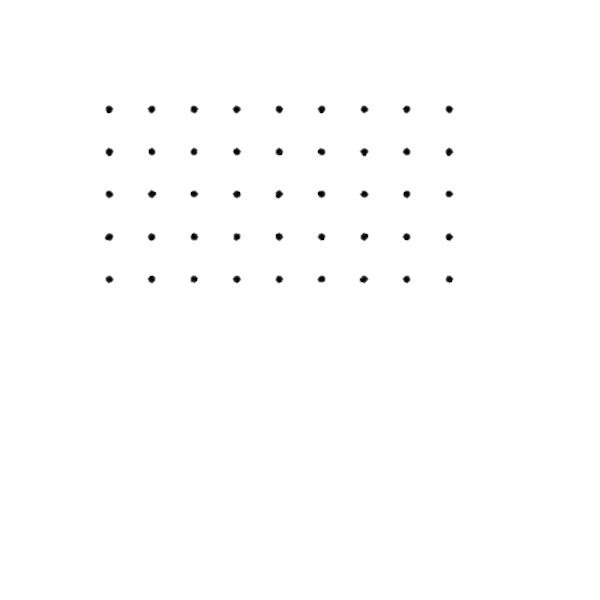
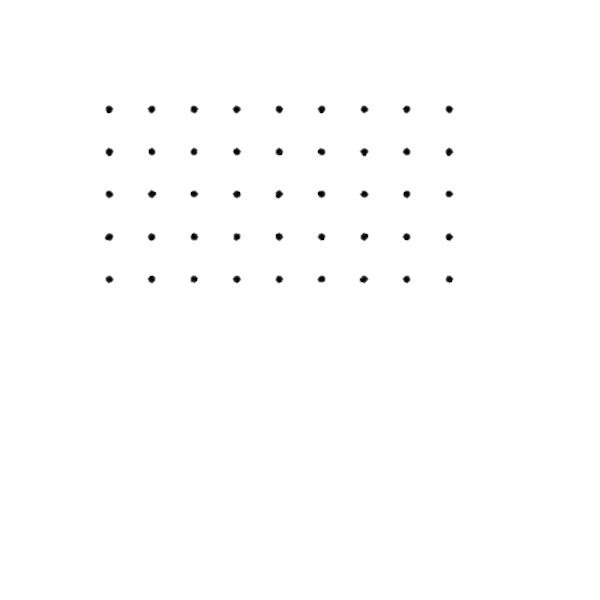
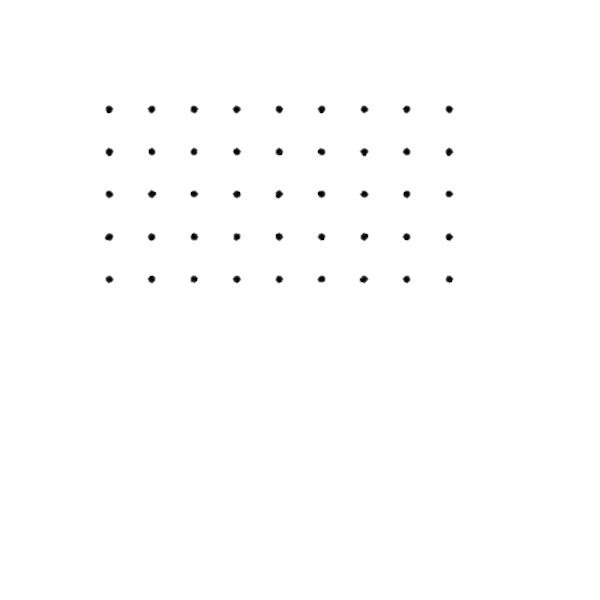
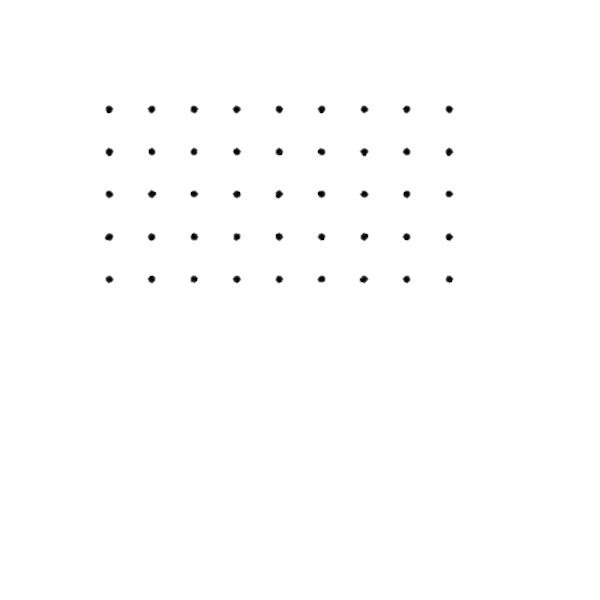
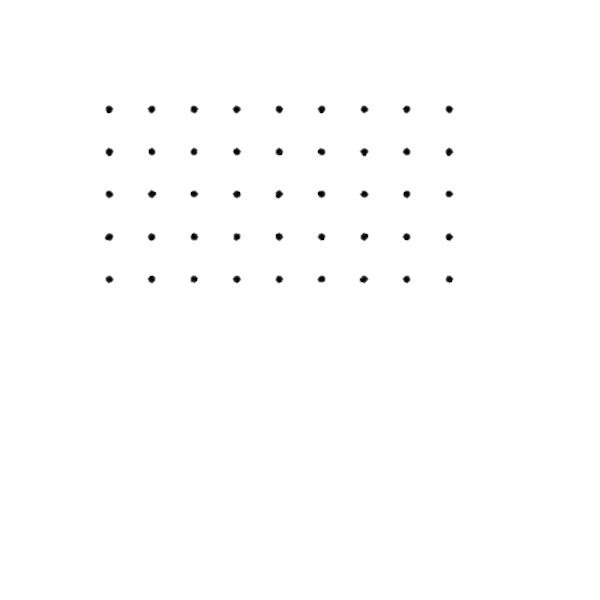
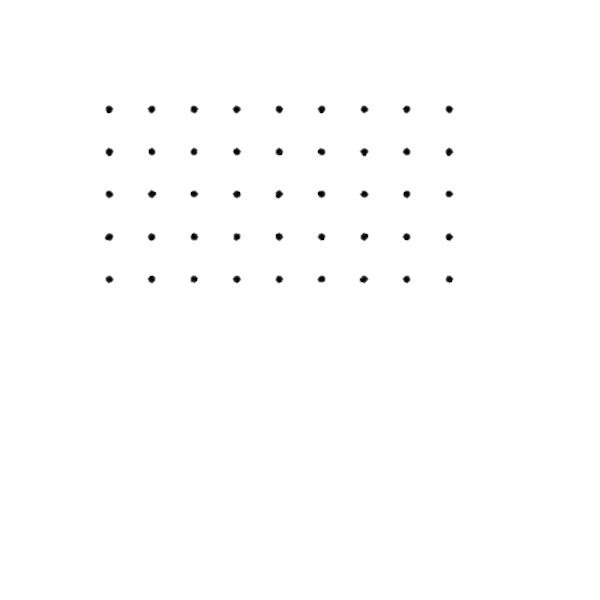
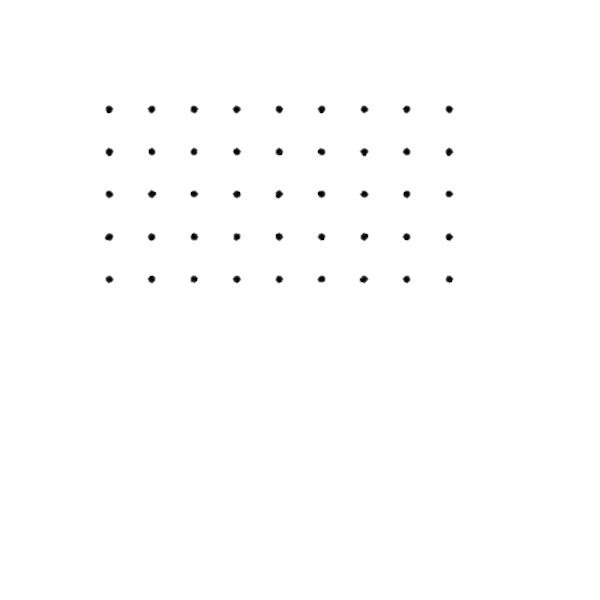
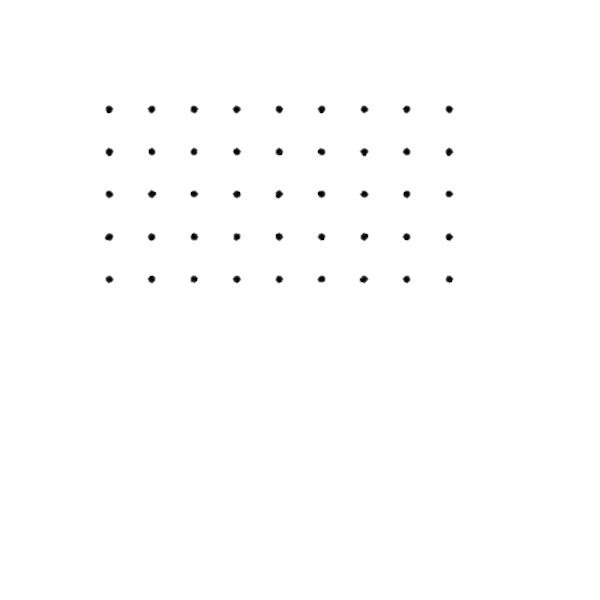
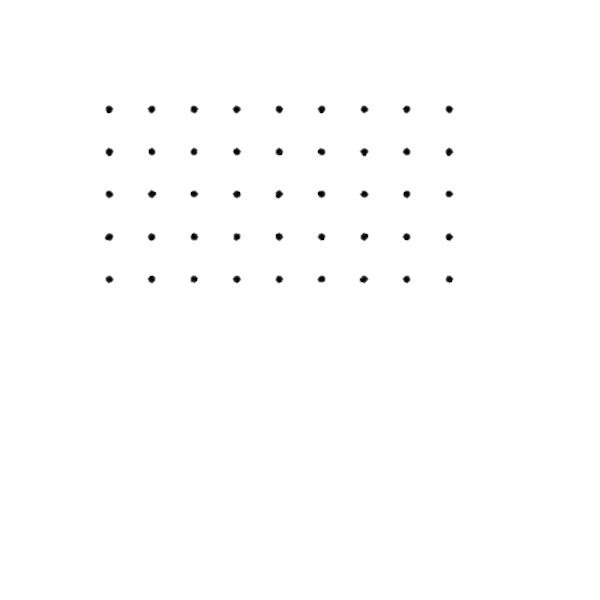
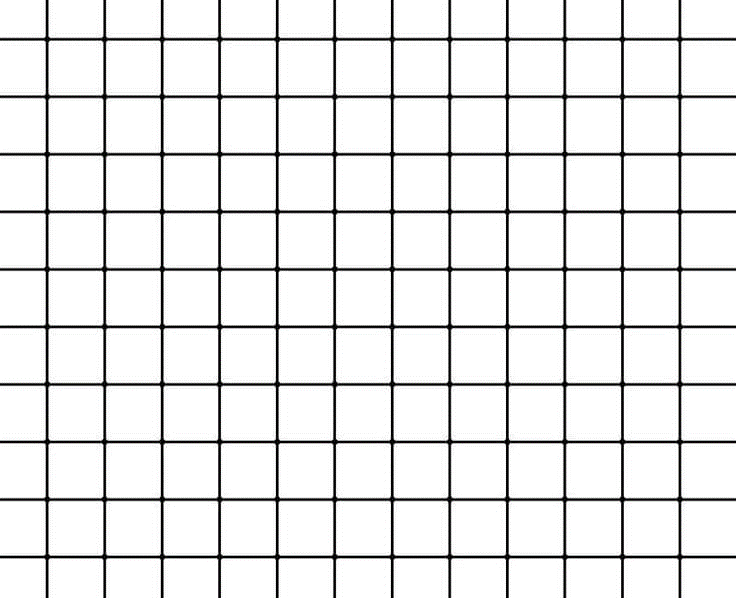
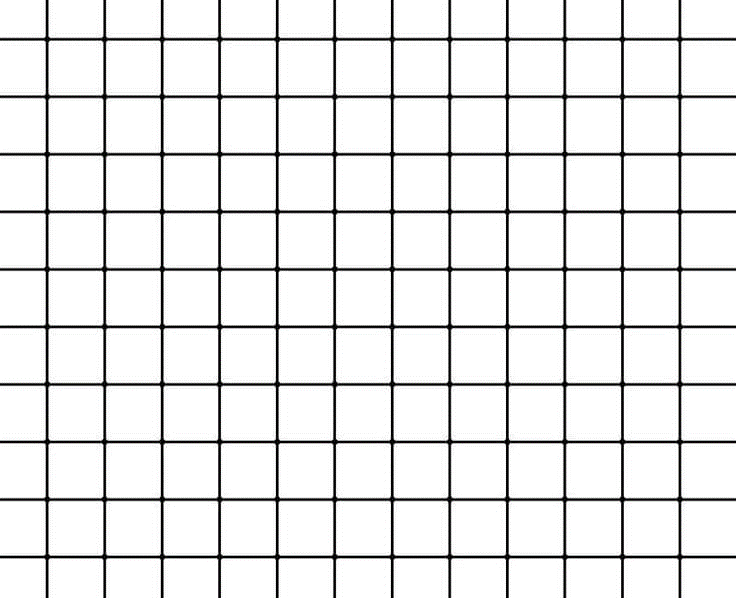
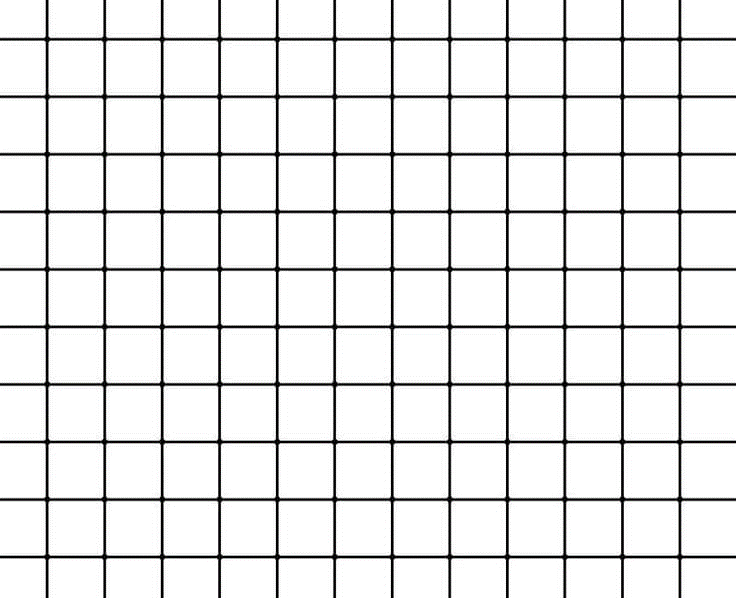
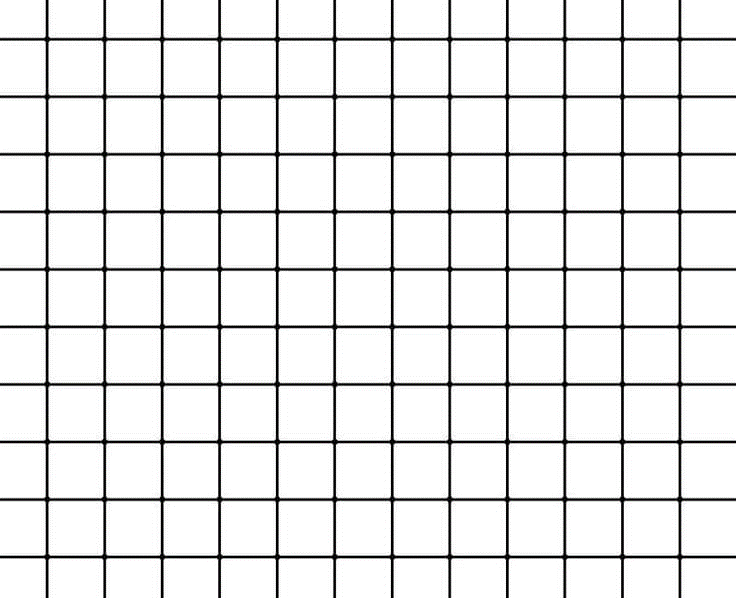
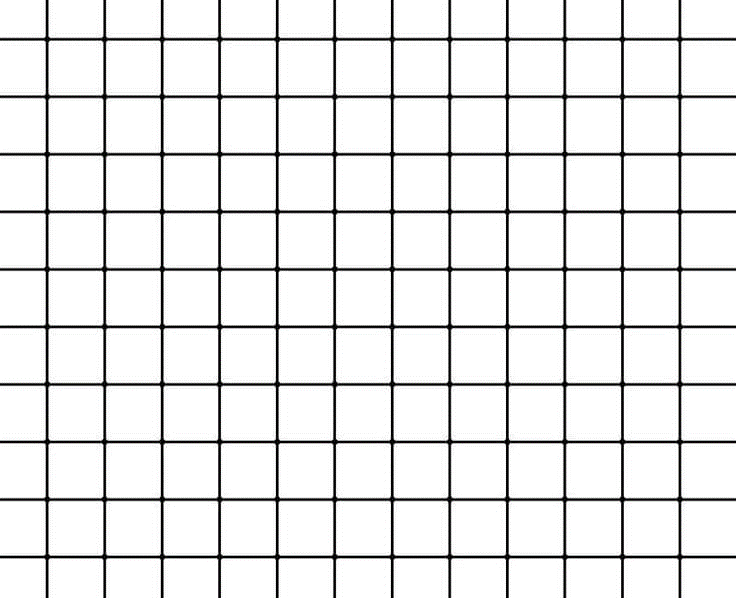
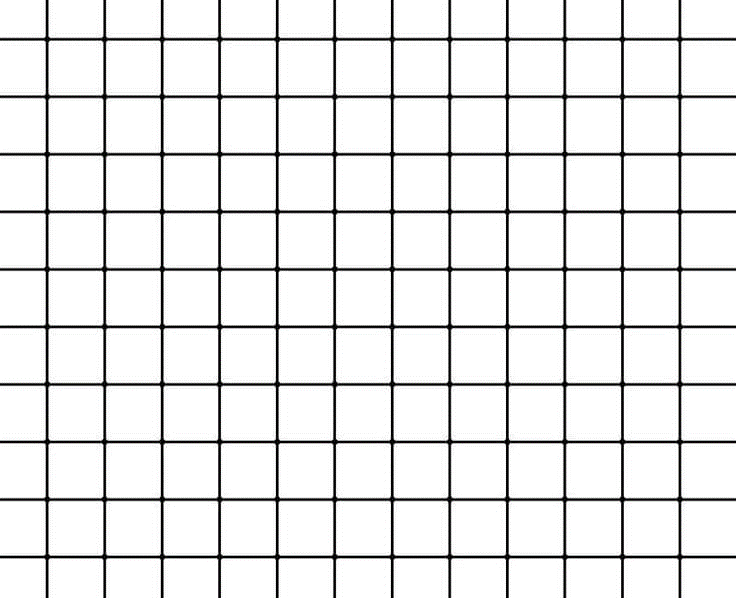
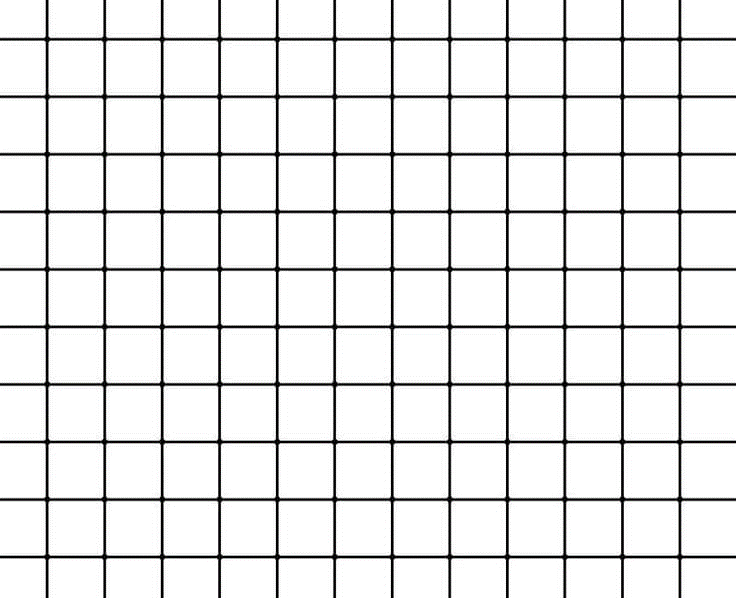
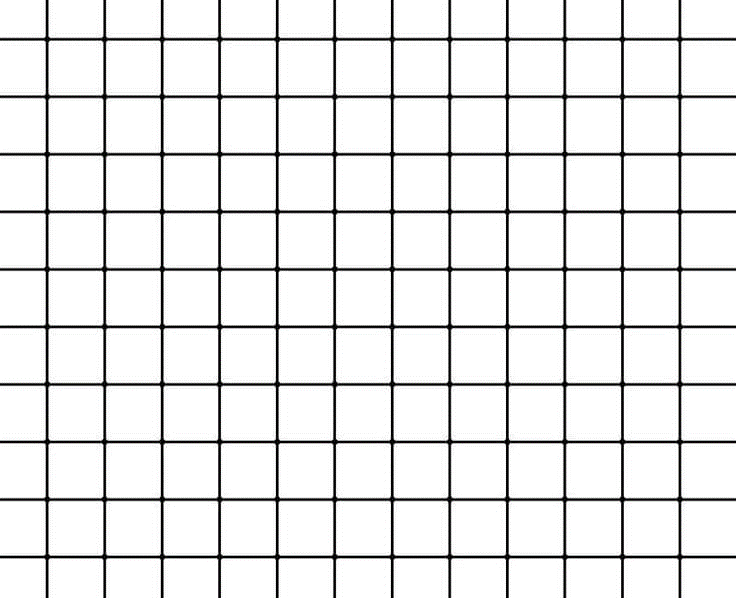
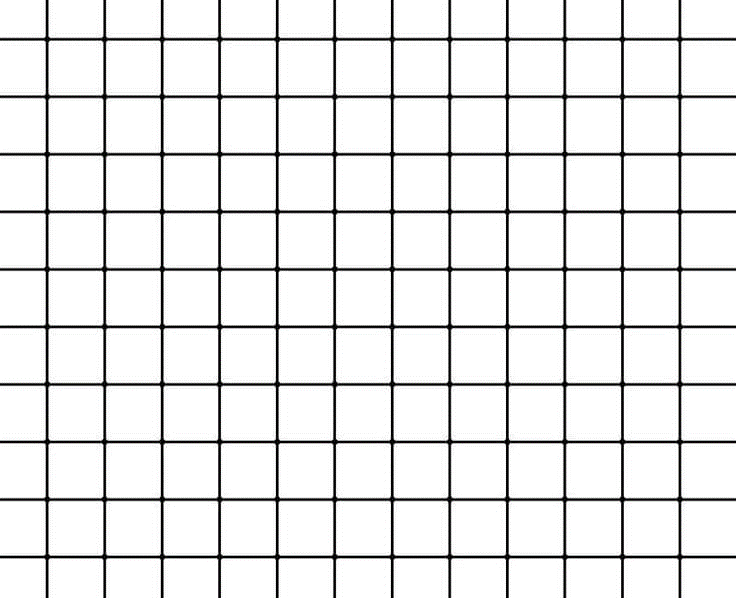
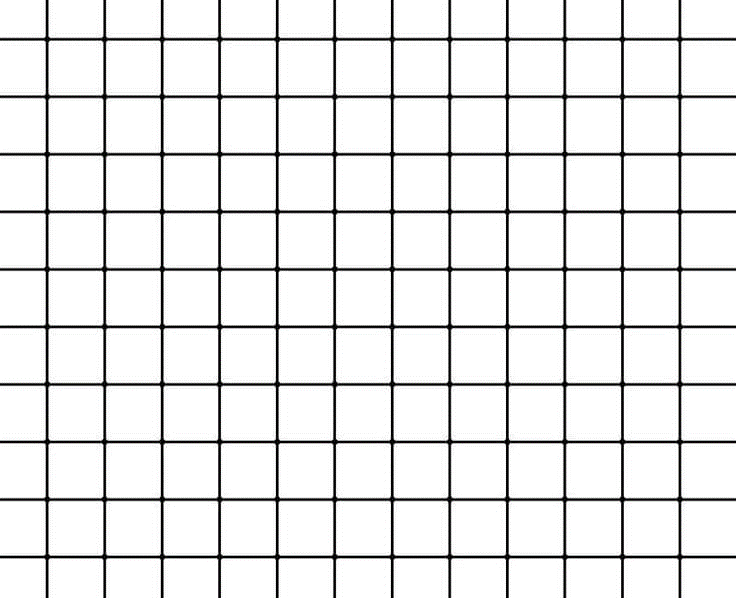
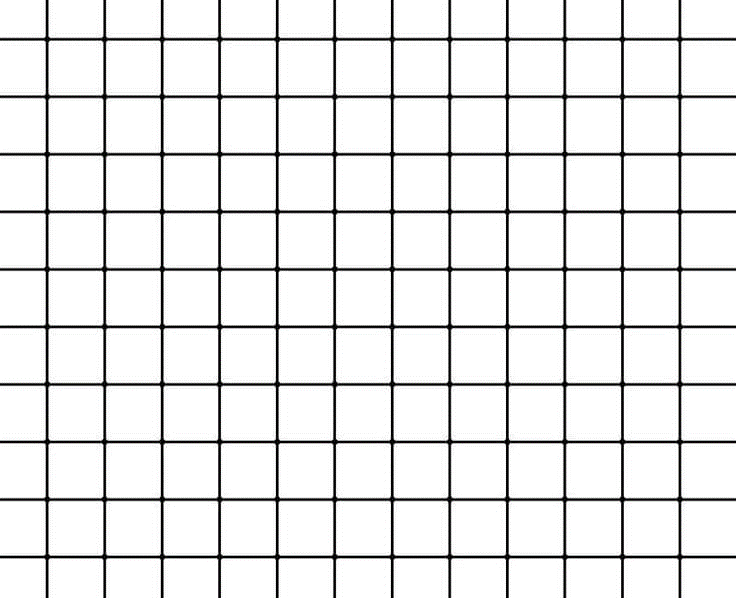
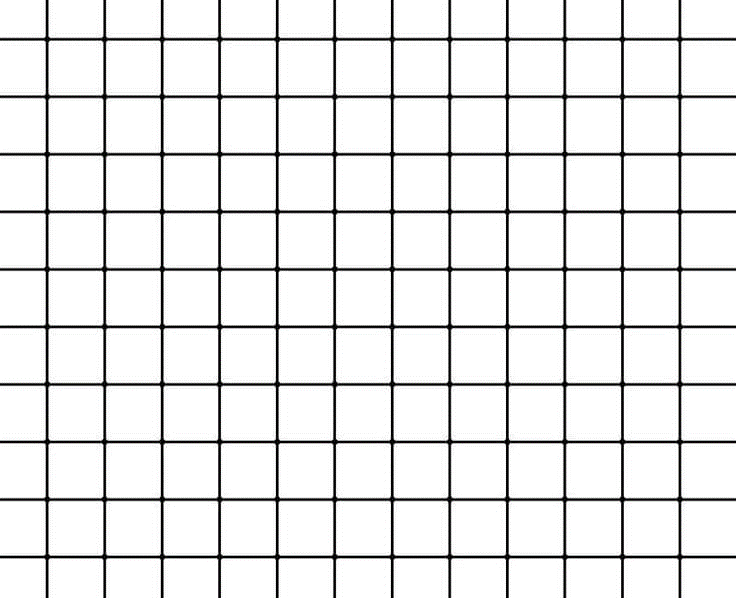
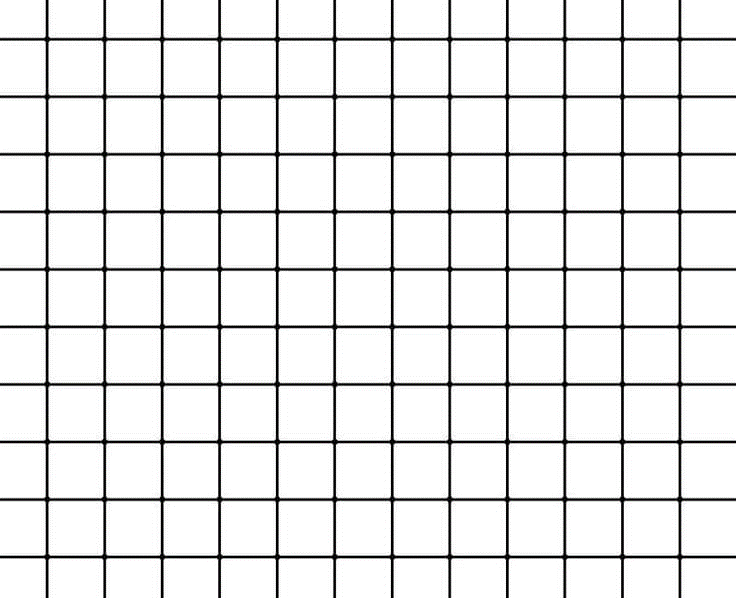
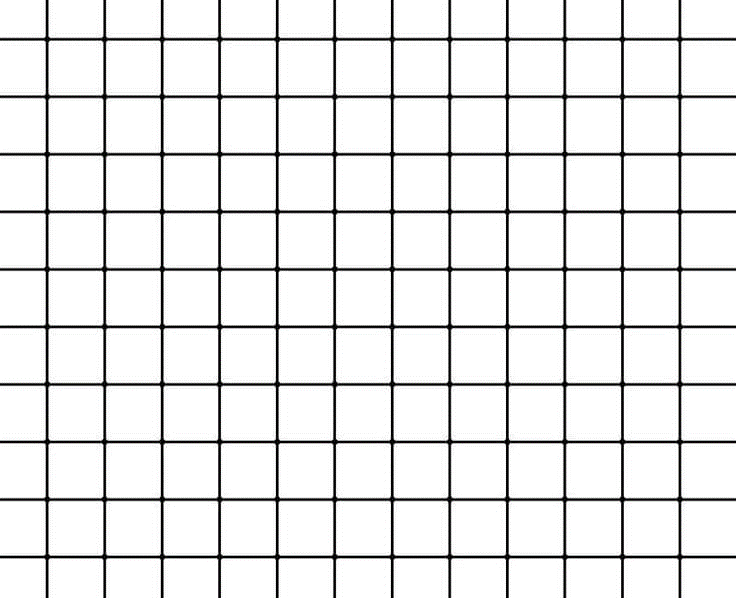
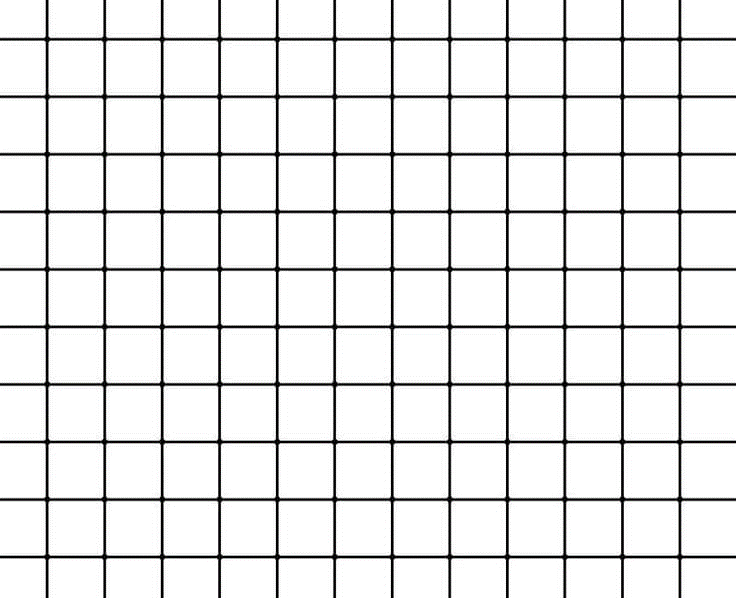
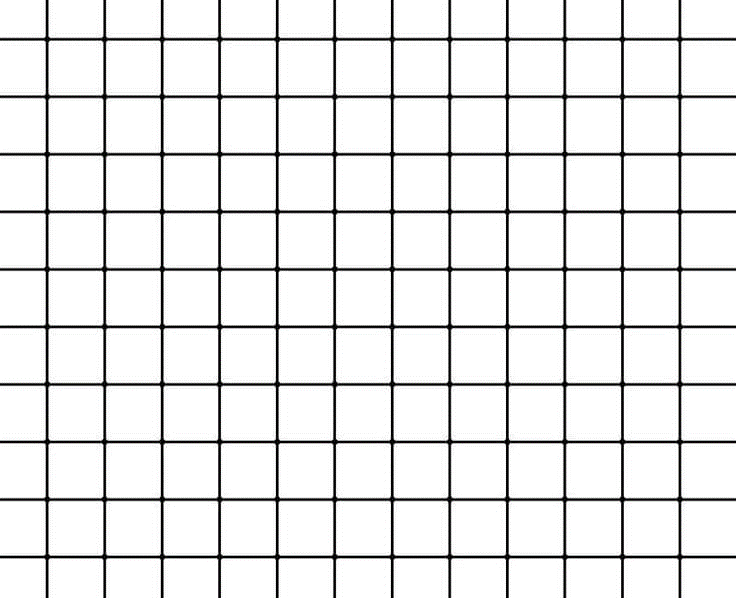
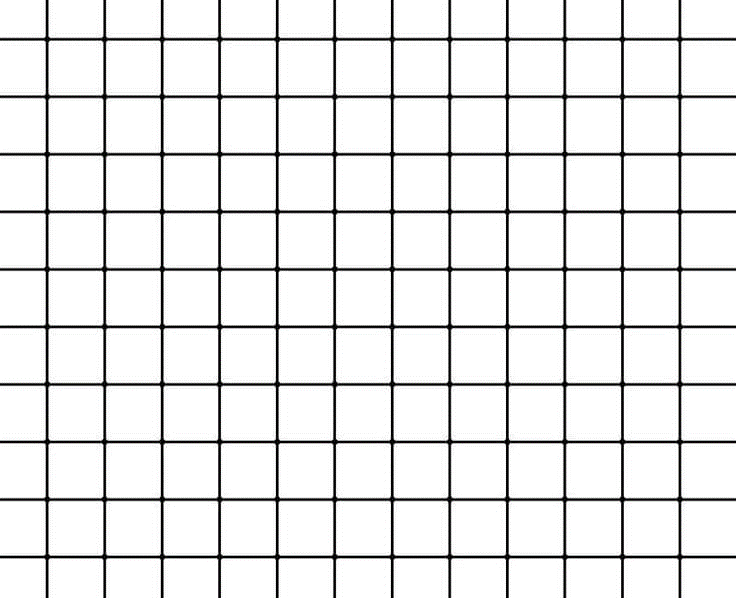
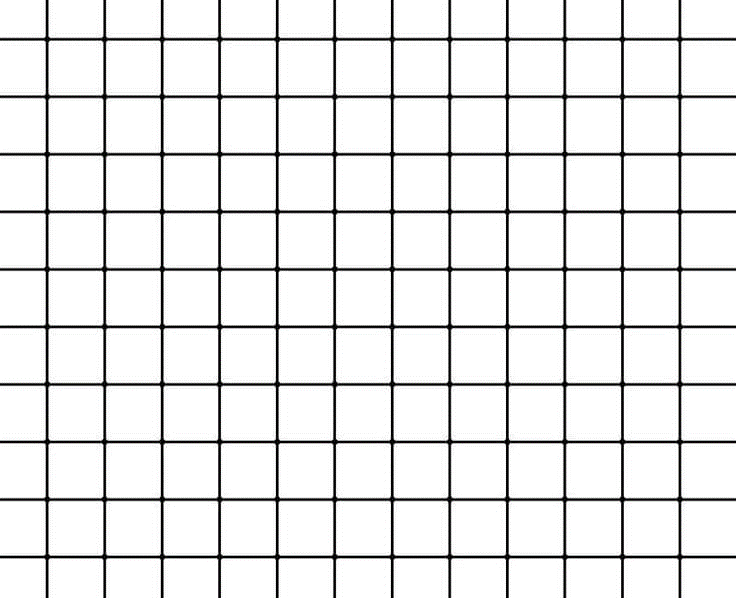
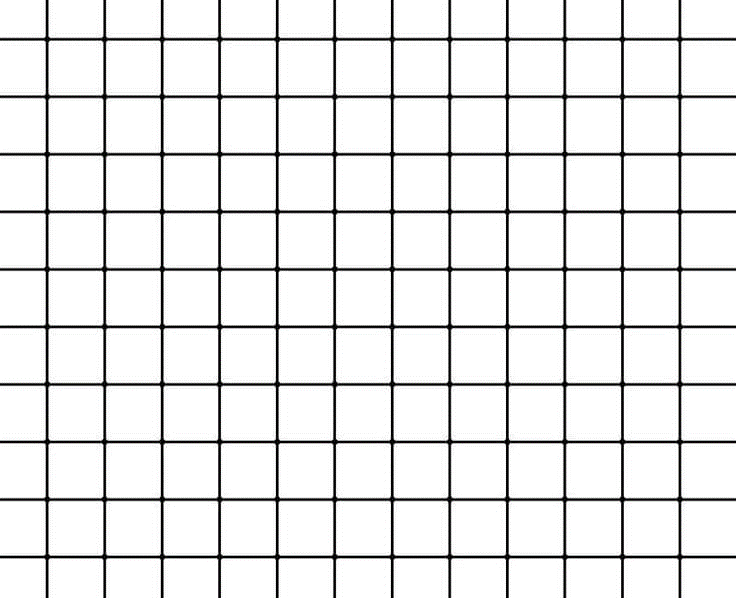
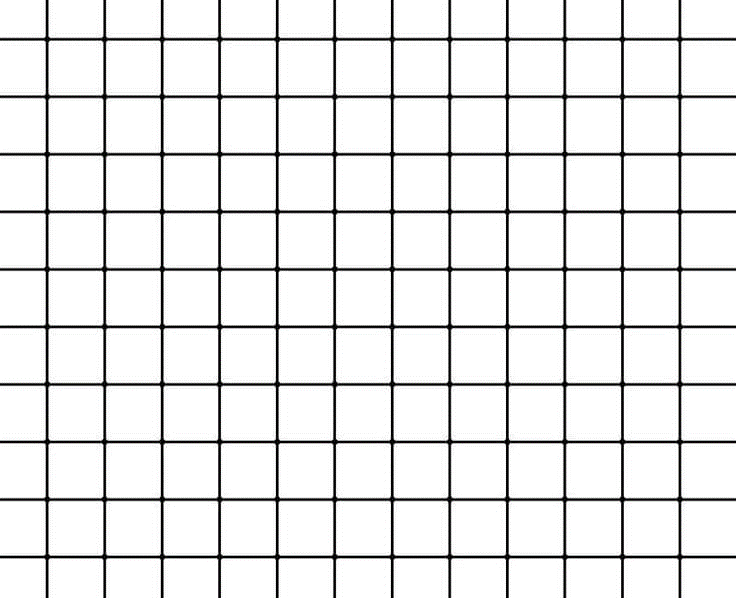
**16**

**12**

**8**

**4**

**0**



12

**Pemeriksaan**

**Tanggal**

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

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35

36

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38

39

40

**Usia Gestasi**

**Target Kenaikan BB**

**12,5 - 18 kg**

**11,5 - 16 kg**

**7 – 11,5 kg**

**5 – 9 kg**

**Mulai Ukur TFU**

**170**

**160**

**150**

**140**

**130**

**120**

**110100**

**90**

**80**

**70**

**60**

**50**

**40**

**30**

**DJJ**

**X**

**Usia Gestasi**

**45cm**

**40cm**

**35cm**

**30cm**

**25cm**

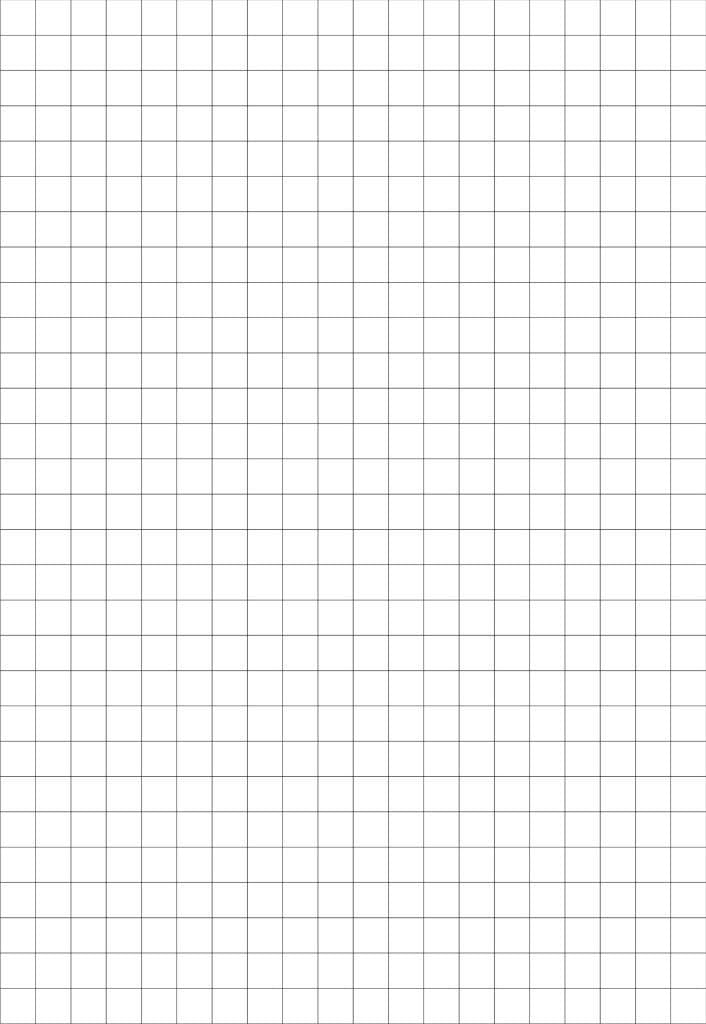
**20cm**

**15cm**

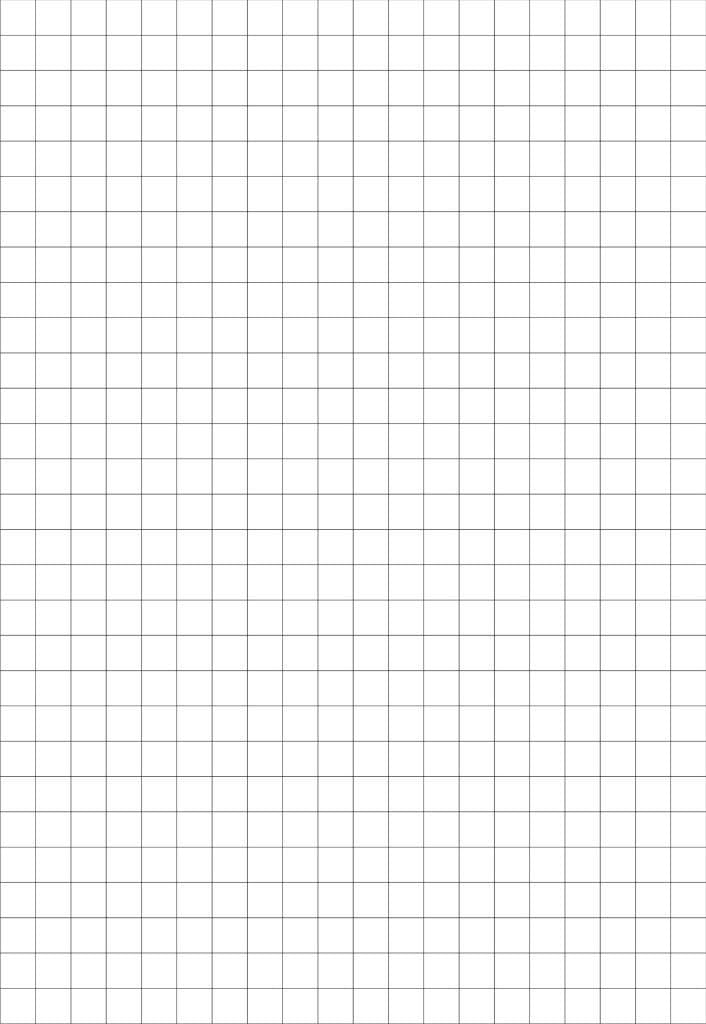
**10cm**

**5cm**

**TPU O**



12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40



**180**

**170**

**160**

**150**

**140**

**130**

**120**

**110**

**100**

**90**

**80**

**70**

**60**

**Tekanan**

**Darah**

**\*Nadi**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Gerakan Bayi | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
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| Urin Reduksi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hemoglobin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kalsium |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Aspirin |  |  |  |  |  |  |  |  |  | \*)MAP = (2 X D) + S MAP > 90 Rujuk  3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**5.2. PELAYANAN KEHAMILAN**

**Diisi oleh Bidan atau Perawat**

**GRAFIK Peningkatan Berat Badan**

**Grafik Peningkatan Berat Badan untuk Katagori IMT Pra Kehamilan**

**kg**

**23**

**22**

**21**

**20**

**19**

**18**

**17**

**16**

**15**

**14**

**13**

**12**

**11**

**10**

**9**

**8**

**7**

**6**

**5**

**4**

**3**

**2**

**1**

**0**

**-1**

**-2**

**-3**

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**MINGGU KEHAMILAN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tanda** | **BB Pra-Kehamilan** | **IMT Pra-Kehamilan** | **Rekomendasi Peningkatan Berat Badan** |
|  |  | <18,5 | 12,5 – 18 kg |
|  |  | 10,5 – 24,9 | 11,5 – 16 kg |
|  |  | 25,0 – 29,9 | 7 – 11,5 kg |
|  |  | ≥30 | 5 – 9 kg |

**6. RINGKASAN PELAYANAN KESEHATAN DOKTER SPESIALIS SPESIALIS**

|  |  |  |
| --- | --- | --- |
| **Tanggal Periksa, Stamp, dan Paraf** | **Keluhan, Pemeriksaan, Tindakan** | **Tanggal Kembali** |
|  |  |  |
|  |  |  |
|  |  |  |

**7. RINGKASAN PELAYANAN PERSALINAN**

**Ibu Bersalin dan Ibu Nifas**

Tanggal Persalinan : ………………….………. Pukul : …………………………..

Umur Kemilan : ………………………….. Minggu

Penolong persalinan : SpOg/ Dokter umum/ Bidan ………………………………...

Cara persalinan : Normal/ Tindakan …………………………………………...

Keadaan ibu : Sehat/ Sakit (Perdarahan/Demam/Kejang/Lokhia berbau/

lain-lain …………………………………… )/Meninggal\*

KB Pasca persalinan : ……………………………………………………………….

Keterangan tambahan : ……………………………………………………………….

\* *Lingkari yang sesuai*

**Bayi Saat Lahir**

Anak ke : ……………………………..

Berat Lahir : ………………………. gram

Panjang Badan : ………………………… Cm

Lingkar Kepala : ………………………… Cm

Jenis Kelamin : Laki-laki/Perempuan/tidak bisa ditentukan\*

**Kondisi bayi saat lahir\*\*:**

[ ] Segera menangis

[ ] Menangis beberapa saat

[ ] Tidak menangis

[ ] Seluruh tubuh kemerahan

**Asuhan Bayi Baru Lahir\*\*:**

[ ] Inisiasi menyusu dini (IMD) dalam 1 jam pertama kelahiran bayi

[ ] Suntikan Vitamin K1

[ ] Salep mata antibiotika profilaksis

[ ] Imunisasi HB0

Keterangan tambahan: ………………………………………..

\* Lingkari yang sesuai

\*\* Beri tanda [√] pada kolom yang sesuai

[ ] Anggota gerak kebiruan

[ ] Seluruh tubuh biru

[ ] Kelainan bawaan: ……………………………

[ ] Meninggal

**8. RINGKASAN PELAYANAN NIFAS**

|  |  |
| --- | --- |
| **Pelayanan Kesehatan**  **Ibu Nifas (KF)** | **RESUME** |
| Kunjungan Nifas 1 (KF1)  (6-48 jam)  Tgl:  Faskes: | Masalah:  Tindakan: |
| Kunjungan Nifas 2 (KF2)  (3-7 hari)  Tgl:  Faskes: | Masalah:  Tindakan: |
| Kunjungan Nifas 3 (KF3)  (8-28 hari)  Faskes: | Masalah:  Tindakan: |
| Kunjungan Nifas 4 (KF4)  (29-42 hari)  Tgl:  Faskes: | Masalah:  Tindakan: |

**Kesimpulan Akhir Nifas**

**Keadaan Ibu\*\*:**

[ ] Sehat

[ ] Sakit

[ ] Meninggal

**Komplikasi Nifas\*\*:**

[ ] Perdarahan

[ ] Infeksi

[ ] Hipertensi

[ ] Lain-lain: Sebutkan

Pastikan bayi mendapatkan pelayanan kesehatan neonatal (KN) dan catat hasil pemeriksaan

pada lembar anak

Kesimpulan: ………………………………………………………………………………

………………………………………………………………………………

**Keadaan Bayi\*\*:**

[ ] Sehat

[ ] Sakit

[ ] Kelainan Bawaan: ………………………..

[ ] Meninggal

**\*\* Beri tanda [√] pada**

**kolom yang sesuai**

**RUJUKAN**

Resume hasil pemeriksaan dan tatalaksana yang telah dilakukan di FTKP, diagnosis akhir

alasan dan alasan dirujuk ke FKRTL:

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

**Umpan balik rujukan**

Tanggal/ bulan/ tahun : …………………………………………………………………….

Diagnosis akhir : …………………………………………………………………………...

Resume (hasil pemeriksaan dan tatalaksana di FKRTL):

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

Anjuran : ……………………………………………………………………..

Rekomendasi tempat persalinan: FKTP/ FKRTL (coret salah satu)

**RUJUKAN**

Resume hasil pemeriksaan dan tatalaksana yang telah dilakukan di FTKP, diagnosis akhir

alasan dan alasan dirujuk ke FKRTL:

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

**Umpan balik rujukan**

Tanggal/ bulan/ tahun : …………………………………………………………………….

Diagnosis akhir : …………………………………………………………………………...

Resume (hasil pemeriksaan dan tatalaksana di FKRTL):

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

Anjuran : ……………………………………………………………………..

Rekomendasi tempat persalinan: FKTP/ FKRTL (coret salah satu)

**9. RUJUKAN**