



નં.પ.ક/ ૨૦૧૭-૧૮/ મેટરનલ હેલ્થ/ સ્ટાન્ડર્ડ લેબર

રૂમ/૬૮૭૫૫૪૭/૧૭

કમિશરશ્રી, આરોગ્ય તબીબી સેવાઓ અને તબીબી
શિક્ષણ (આ.વિ.), બ્લોક નં.૫, બીજો માળ, ડૉ. જીવરાજ મહેતા
ભવન, ગાંધીનગર.

ડૉ. પ્રકાશ વાધેલા.
અધિક નિયામક
(પ.ક.)

ફોન નં.-૦૭૯-૨૩૨ ૫૩૩૧૧
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તા. ૩૦/૧૧/૨૦૧૭

વિષય : જાહેર આરોગ્ય સંસ્થા ખાતે લેબરરૂમ રજીસ્ટર બાબત.

આર.એમ.એન.સી.એચ.એ ની વ્યુહ રચના અંતર્ગત દરેક પ્રસૂતિ દરમયાન કૌશલ્ય સહર સેવાઓએ માતા અને નવજાત શિશુ મૃત્યુદર ધરાડવામાં અગત્યનો ભાગ ભજવે છે. પ્રસૂતિ દરમયાન ઉત્પન્ન થતી જટીલતાઓની સમયસર ઓળખ અને જરૂરી મેનેજમેન્ટ (દરમયાનગીરી) ની એક સમાન પદ્ધતિથી નોંધ માતા અને અને નવજાતશિશુ આરોગ્ય સેવાઓના મુલ્યાંકન માટે અંત્યત જરૂરી છે.

ભારત સરકારશ્રી ના લેબર રૂમ રજીસ્ટર તથા M NH Toolkit – Bed Head Ticket નો નમુનો આ સાથે સામેલ છે. આપશ્રીનાં આપનાં વિસ્તારની તમામ જાહેર આરોગ્ય સંસ્થા ખાતે સદરહુ બાબતનાં અમલ માટે આ સાથે જણાવવામાં આવે છે. માતા આરોગ્ય સંબંધિત સંસ્થાકીય સ્વાસ્થ્ય સેવાઓનાં ગુણવત્તામાં સુધારો લાવવા મદદરૂપ થશે. જિલ્લા/ કોરોના અનુકૂળતા પ્રમાણે તમામ જાહેર આરોગ્ય સંસ્થાઓમાં એક સાથે અથવા તબક્કાવાર (પ્રથમ તબક્કા એક.આર.યુ અને હાઈ ડિલીવરી પોઇન્ટ પ્રતિ માસ ૫૦ કે તેથી વધુ પ્રસૂતિ ધરાવતાં કેંદ્ર અને દીતીય તબક્કામાં તમામ જાહેર આરોગ્ય સંસ્થા) અમલીકરણ કરી શકે.

ઉપરોક્ત લેબરરૂમ રજીસ્ટર તથા Bed Head Ticket માટે જરૂરી પ્રિન્ટિંગનો ખર્ચ નિયમાનુસાર આર.કે.એસ અંતર્ગત પણ કરી શકાશે.

બિડાયા : ઉપર મુજબ

(ડૉ. પ્રકાશ વાધેલા)

પ્રતિ

- (૧) મેડીકલ સુપ્રિટેન્ડન્ટ, મેડીકલ કોલેજ હોસ્પિટલ,....તમામ.
- (૨) મુખ્ય જિલ્લા તબીબી અધિકારી સહ સીવીલ સર્જનશ્રી,... જીલ્લા હોસ્પિટલ....તમામ.
- (૩) મુખ્ય જિલ્લા આરોગ્ય અધિકારીશ્રી,....જિલ્લાપંચાયતની કચેરી,...તમામ.
- (૪) મેડીકલ ઓફિસર ઓક્સ હેલ્થ,... મ્યુનિસિપલ કોરોનાની કચેરી,...તમામ.

નકલ રવાના:

- તબીબી અધિક્ષકશ્રી, પેટા જિલ્લા હોસ્પિટલ,...તમામ.
- અધિક્ષકશ્રી,....સામુહિક આરોગ્ય કેંદ્ર,....તમામ.
- મેડીકલ ઓફીસર,...પ્રાથમિક આરોગ્ય કેંદ્ર,....તમામ.

Bed-Head Ticket (Maternity ward)

S. No.
MCTS No*
Facility registration number (OPD/IPD)
Aadhar number
Whether JSY beneficiary (Y/N)
Name
Age
W/o or D/o
Address
Mobile number (Family /others)
Religion
Caste SC/ST/Others
Date of admission:
Date of discharge:
Reason for admission:
Date and time of delivery/any other obstetric procedure:
Type of Delivery: Normal/Assisted/LSCS:
Outcome of delivery (live birth/still birth/abortion):
Sex of baby: (M/F)
Weight of baby: in gms./Kgs.)
OPV:
Hepatitis B:
Date on which birth-day dose administered:
PPIUCD inserted on:
Name of unit in charge:
Name of assisting doctor:
Name of ASHA:
If referred out: Referral Note, indicating reason and place of referral:

*It MCTS number is not generated, then the MCTS no. is to be generated by the treating health facility

Admission Notes

Whether came by referral, if yes please specify the facility and indication of referral:

Complaints at the time of admission:

LMP and EDD:

Obstetric complication in previous pregnancy: If yes, then Please tick (✓)

- APH
- Eclampsia
- PIH
- Anaemia
- Obstructed labour
- PPH
- Abortion/still births/congenital anomaly
- Any other, please specify

Past History: If yes, then Please tick (✓)

- TB
- Hypertension
- Heart disease
- Diabetes
- Asthma
- Any other, please specify

History of:

- Infertility/C- Section/Twins/Breach/Blood transfusion
- Please also specify other significant history:

Family history (if significant) Ask for DM, HT, Asthma etc.:.....

Allergies/adverse reactions, if any:.....

Treatment prescribed/taken before admission:.....

Report of Investigations done before admission:.....

- Hb.....
- Urine Albumin.....
- Urine Sugar.....
- Blood Sugar.....
- Any other (Pregnancy test/Blood Group and Rh Typing/HIV/Syphilis/HBsAg etc.).....

Vital Parameters/General Examination at the time of admission:

- Temperature.....
- BP
- Pulse
- Respiration.....
- Weight.....
- Pallor.....
- Jaundice.....
- Pedal Oedema

Systemic Examination:

- Heart.....
- Lungs.....
- Breast.....

Abdominal Examination:

- Fundal height (gestational period):.....
- Lie/presentation:.....
- Foetal movement: Normal/Increased/Decreased/Absent
- Foetal Heart Rate/minute.....

P/V Examination:.....

If in labour, date and time of onset of labour

Provisional diagnosis:.....

Investigation advised:.....

Treatment advised:.....

Remarks:

Continuation Sheet

Delivery Note

- Outcome of delivery (FT Live birth/ /Still birth/ Abortion)
- Date and time of delivery/Abortion
- Gestation age in weeks at the time of delivery/abortion
- Delivery conducted by (name and designation)/ abortion
- Type of delivery : normal / assisted (specify)/ LSCS/others
- Complications if any during delivery
- Any Medical/surgical Interventions (e.g Injectable drugs, ARM etc) given
- Indication for the intervention
- Date and time of transfer to post natal ward
- Condition at transfer to post natal ward.
- If referred, reason and place for referral (both for mother and baby)
- Incase of death pl specify Maternal or Neonatal (other than stillbirth),
- Cause of death and time
- Remarks, if any

Baby Note

- Did the baby cry immediately after birth? (Y/N)
- Temperature maintained (Y/N)
- Breast feeding initiated (Y/N)
- Did the baby require resuscitation? (Y/N)
- Sex (M/F)
- Weight (in grams)
- Time of initiation of Breastfeeding
- Birth doses:
- BCG (Y/N)
- OPV (Y/N)
- Vitamin K (Y/N)
- Hepatitis B (Y/N)
- Any Congenital Anomaly, please specify
- Any other complication, please specify

Operation/Obstetric Procedure Note

Indication for the procedure

Whether Patient/Guardian explained about the procedure and probable consequences:

Consent of patient/ Guardian: (Y/N)

Elective / emergency

Type of anesthesia

Time at. Procedure started ----- b. Procedure ended-----

Operation Note:

Condition at transfer to ward

Treatment advised:

Signature of doctor conducted the procedure

Investigation Report Sheet

Note on Pre Anesthetic Check up

Continuation Sheet

Notes of Post-Partum Care of the mother

Note: Please Tick, where ever applicable or write remark

	Day 1		Day 2	
	Morning	Evening	Morning	Evening
Any complaints				
Pulse Rate				
Blood Pressure				
Temperature				
Pallor				
Breasts-Soft/Engorged				
Nipples-Cracked/Normal				
Uterus tenderness- Present/absent				
Bleeding P/V- Excessive/normal				
Lochia-Healthy/foul smelling				
Episiotomy/Tear- Healthy/Infected				
Family Planning counselling				
Counselling on Breast milk expression				
Complications, if any, please specify				
Referral if required				
Treatment given(Y/N), give detail				
Signature of attending nurse				
Signature of treating doctor				

Care of baby*

	Day 1		Day 2	
	Morning	Evening	Morning	Evening
Urine passed*				
Stool passed*				
Diarrhea*				
Vomiting*				
Convulsions*				
Activity (good/lethargic/no response on stimulation)				
Sucking (good/poor)				
Breathing (fast/difficult)				
Chest indrawing (Present/absent)				
Temperature				
Jaundice*				
Condition of umbilical stump (Dry/Infected)				
Skin pustules *				
Any – complications(Y/N), if yes, write details				
Signature of attending nurse				

*- Please Tick

Treatment Sheet
to be maintained by the nurses

Day 1 and Date:

Medication Name	Dosage	Instructions (Frequency/Route)	Time of administration	Signature

Day 2 and Date:

Medication Name	Dosage	Instructions (Frequency/Route)	Time of administration	Signature

Day 3 and Date:

Medication Name	Dosage	Instructions (Frequency/Route)	Time of administration	Signature

Recording Sheet for Vital Parameters (Mother)

(Nurses notes)

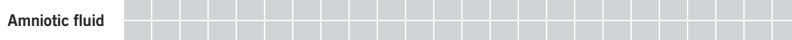
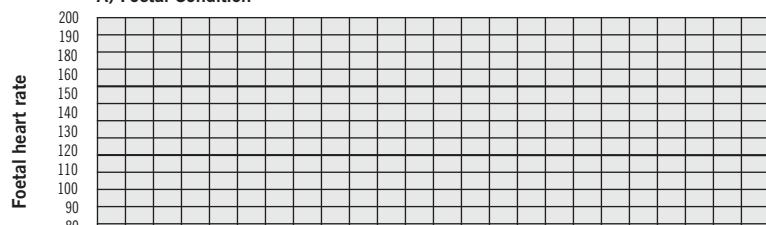
The Simplified Partograph

Identification Data

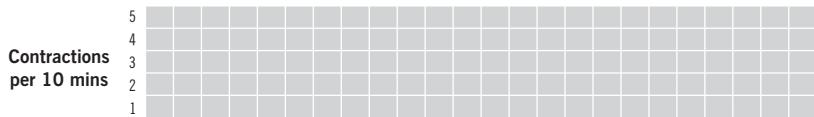
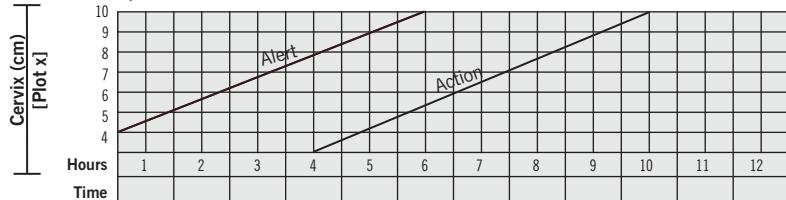
Name	W/O	Age	Parity	Reg. No.
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Date and Time of admission: _____ Date and Time of ROM: _____

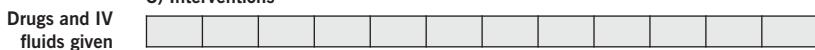
A) Foetal Condition



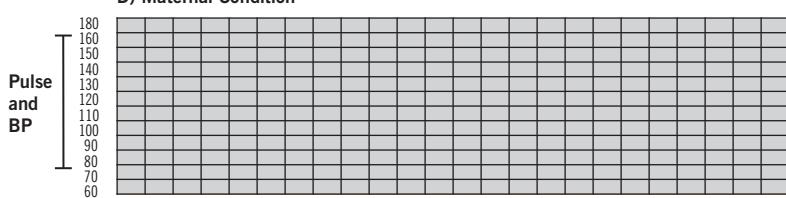
B) Labour



C) Interventions



D) Maternal Condition



Discharge Slip

1. S. No.
2. MCTS No*
3. Facility registration number (OPD/IPD)
4. Aadhar number
5. Whether JSY beneficiary (Y/N)
6. Name
7. Age
8. W/o or D/o
9. Address
10. Mobile number (Family /others)
11. Religion
12. Caste SC/ST/Others

Name of the SC/PHC/CHC/FRU/DH:

OPD/Emer. Reg. No.: _____

Name of the Mother: _____

Age: _____ yrs

Address: _____

Admission: Date ____ / ____ / ____ Time: _____

Delivery: Date ____ / ____ / ____ Time: _____

Discharge: Date ____ / ____ / ____ Time: _____

Mode of Delivery:

Normal

Assisted

LSCS

Indication for:

Assisted / LSCSI: _____

Delivery Outcome:

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> FTND | <input type="checkbox"/> Preterm |
| <input type="checkbox"/> Stillbirth | |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Any other |

Number of Births:

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Multiple/Twin pregnancy |
|---------------------------------|--|

Details of the baby:

Sex: Male Female Weight: _____ Kgs _____ gms

BF initiation within 1 hr of birth: Yes No

Pre-term – (in weeks):

Still birth- Y/N

Danger signs explained Y/N

Follow Up date given Y/N

Any history of complications:

Mother Complications	Y	N	Baby Complications	Y	N
PPH			Apnea/breathing difficulties		
Eclampsia			Cyanosis		
Heart disease			Hypothermia		
Stroke			Hyperthermia		
Epilepsy/seizure			Failure to cry		
Anaemia			Lethargy		
Any other			Any other		

Investigation done:

Investigations done	Results	
	Mother	Baby (if any, suggested by doctor)
Hb		
Blood group		
Urine analysis		
Blood tests for HIV		
Blood sugar		
Serum Bilirubin		
Any other		

Ultrasound- (If conducted, reason and finding)

Referral for mother and/or baby:Mother: Yes NoBaby: Yes No

Referral facility: _____ PHC/CHC/DH/Pvt Hosp

Reasons for referral: _____

At discharge time condition of:

Mother: Stable Not stableBaby: Stable Not stable**Postnatal Care Provided**Birth Dose: OPV BCG HEP B VIT KFamily Planning counseling provided: Yes No

PPIUCD Insertion done on-----

Additional advice given at time of discharge:

Next follow-up: Date ____/____/_____ Place: _____

Discharging Health Care Provider:

Name: _____

Signature: _____

Designation: _____

Phone number: _____

Date ____/____/_____ Time: _____



सत्यमेव जयते



Labor Room Register

Facility :.....

District :.....

Start Date (Month/Year) **End Date (Month/Year)**

register

*Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done

****States may consider including steps of newbo**

Labor F

Resuscitation: Position, Suction, Stimulation

Please fill in 'NA' if column is not applicable

Labor Room Register

*Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done

Please fill in 'NA' if column is not applicable

Labor Room Register

Details of Interventions for Delivery			Details of Delivery			Information about Baby			Complications		In case of Referral		Condition of mother and baby at discharge			Postpartum Family Planning		Addtional Info. /Follow up details
Inj. Magnesium Sulfate (Yes/No)	Episiotomy (Yes/No)	AMTSL (Yes/No)							Mother	Baby	Mother	Baby						
Oxytocin IM (Yes/No ; if 'No' then specify any other uterotonic used)			Date	Time	Type of delivery (Normal/Assisted Delivery (Instrumental/Vacuum) Caesarean) If Caesarean, Specify indications													
Delayed cord clamping (1-3min (yes/no))						Conducted by		Delivery outcome Mother (Alive /Maternal Death)	Baby									
Antibiotics (Yes/No)									Single / Multiple									
Blood Transfusion (Yes/No)										Term (Full term/ preterm / post term)								
										Alive/Fresh Stillbirth / Macerated Stillbirth / Newborn Death								
											Vitamin K1 given (Yes/No)							
												BCG						
												OPV						
												Hep B						
													Complication (APH; PPH; Pre-Eclampsia; Eclampsia; Sepsis; Obs. Labour; Prolonged labour; Others (specify))					
													Complication (Sepsis; Asphyxia; LBW; Pre Maturity; Others (specify))					
													Reason					
													Referred to					
													Reason					
													Referred to					
														Date and Time				
														BP				
														Temp				
														Bleeding PV (Yes/No)				
														Temp				
														Feeding (Yes/No)				
														Respiratory rate				
														Counselling (Yes/No)				
														Method chosen (LAM, Condoms; Injectable; PPIUCD; Male Sterilization; PPS; Others (Specify))				
														Date of method adopted				
																	Signature of LR I/C	

**States may consider including steps of newborn resuscitation: Position, Suction, Stimulation, Reposition, Bag & Mask Ventilation.

Please fill in 'NA' if column is not applicable

Labour Room Register

Year SN	Month SN	Client Detail	Obstetric History	Admission Details	Detail of interventions for Delivery	Details of Delivery	Information about Baby	Complications	In case of referral	Condition of the mother and baby at discharge	Postpartum Family planning	Addition Info./Follow up details					
1	2	3	4	5	6	7	8	9	10	11	12	13					
		Registration No.	LMP/EDD	Date _____ Time _____ Direct in labour <input type="checkbox"/>	Partograph Filled Inducted* <input type="checkbox"/> Augmented* <input type="checkbox"/> Inj. <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Inj. Magnesium <input type="checkbox"/> Sulfate <input type="checkbox"/> Episiotomy <input type="checkbox"/> AMTSL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type of Uterotonic Oxytocin IM <input type="checkbox"/> If others, then specify: _____	Date _____ Time _____ Type: Normal <input type="checkbox"/> Assisted Delivery <input type="checkbox"/> (Instrumental, Vacuum, etc.) <input type="checkbox"/> Caesarean <input type="checkbox"/> If caesarean, Indication: Conducted By: _____ Mother: Alive <input type="checkbox"/> Maternal <input type="checkbox"/> Death <input type="checkbox"/> Baby: Single <input type="checkbox"/> Multiple <input type="checkbox"/> Term <input type="checkbox"/> Preterm <input type="checkbox"/> Alive <input type="checkbox"/> Still birth: Fresh <input type="checkbox"/> Macerated <input type="checkbox"/> New born death <input type="checkbox"/>	Identification No _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Weight (Kgs): If dried immediately after birth: Yes <input type="checkbox"/> No <input type="checkbox"/> Resuscitation required** Yes <input type="checkbox"/> No <input type="checkbox"/> Mother: APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____ Breast feed within 1 hour Yes <input type="checkbox"/> No <input type="checkbox"/> If not, mention time: _____ Vitamin K1 given Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccination done BCG <input type="checkbox"/> OPV <input type="checkbox"/> Hep B <input type="checkbox"/>	Mother: Reason APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Reason Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____ Bleeding PV _____ Referred to Mother: BP Temp Baby: Temp Feeding _____ Respiratory Rate _____	Date and time of Discharge Reason _____ _____ Mother: BP Temp Baby: Temp Feeding _____ Respiratory Rate _____	Counselling Yes <input type="checkbox"/> No <input type="checkbox"/> Method chosen: LAM <input type="checkbox"/> Condoms <input type="checkbox"/> Injectable <input type="checkbox"/> PPIUCD <input type="checkbox"/> Male Sterilization <input type="checkbox"/> PPS <input type="checkbox"/> Others <input type="checkbox"/> Date of method adopted _____	Signature of LR I/C						
				MCTS No.	Gravida												
				Name and age	Parity												
				Husband's/Fathers/Guardians Name	Abortion												
				Address	Living children												
				Mobile No.	Previous LSCS (Y/N)												
				BPL/MBS reg: Y/ N	Other previous complications:												
				Aadhar No.													
				Bank details													
				ASHA's name & contact no.	Identified as High Risk Specify:												
				Registration No.	LMP/EDD	Date _____ Time _____ Direct in labour <input type="checkbox"/>	Partograph Filled Inducted* <input type="checkbox"/> Augmented* <input type="checkbox"/> Inj. <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Inj. Magnesium <input type="checkbox"/> Sulfate <input type="checkbox"/> Episiotomy <input type="checkbox"/> AMTSL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type of Uterotonic Oxytocin IM <input type="checkbox"/> If others, then specify: _____	Date _____ Time _____ Type: Normal <input type="checkbox"/> Assisted Delivery <input type="checkbox"/> (Instrumental, Vacuum, etc.) <input type="checkbox"/> Caesarean <input type="checkbox"/> If caesarean, Indication: Conducted By: _____ Mother: Alive <input type="checkbox"/> Maternal Death <input type="checkbox"/> Baby: Single <input type="checkbox"/> Multiple <input type="checkbox"/> Term <input type="checkbox"/> Preterm <input type="checkbox"/> Alive <input type="checkbox"/> Still birth: Fresh <input type="checkbox"/> Macerated <input type="checkbox"/> New born death <input type="checkbox"/>	Identification No _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Weight (Kgs): If dried immediately after birth: Yes <input type="checkbox"/> No <input type="checkbox"/> Resuscitation required** Yes <input type="checkbox"/> No <input type="checkbox"/> Mother: APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Reason Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____ Breast feed within 1 hour Yes <input type="checkbox"/> No <input type="checkbox"/> If not, mention time: _____ Vitamin K1 given Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccination done BCG <input type="checkbox"/> OPV <input type="checkbox"/> Hep B <input type="checkbox"/>	Mother: Reason APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Reason Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____ Bleeding PV _____ Referred to Mother: BP Temp Baby: Temp Feeding _____ Respiratory Rate _____		Date and time of Discharge Reason _____ _____ Mother: BP Temp Baby: Temp Feeding _____ Respiratory Rate _____	Counselling Yes <input type="checkbox"/> No <input type="checkbox"/> Method chosen: LAM <input type="checkbox"/> Condoms <input type="checkbox"/> Injectable <input type="checkbox"/> PPIUCD <input type="checkbox"/> Male Sterilization <input type="checkbox"/> PPS <input type="checkbox"/> Others <input type="checkbox"/> Date of method adopted _____	Signature of LR I/C			

*Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done).

**States may consider including steps of newborn resuscitation: Position, Suction, Stimulation, Reposition, Bag & Mask Ventilation.

