NEWBORN STABILIZATION UNIT (NBSU)

Community Health Center / Civil Hospital ....., District.....

NEONATAL CASE RECORD SHEET

(Developed by National Health MIssion)

NBSU Reg. No.....

Doctor In charge.....

RCH No.

Baby of (Mother's Name)			Sex: Male / Female / Ambiguous
Father's Name			Category: General / OBC / SC / ST
Complete Address with Village Name / Ward No.			
Contact No. & Relation	1.	2.	
Date and Time of Birth	...../...../20..... ..... :	Birth Weight (grams) :	
Date and Time of Admission	...../...../20..... ..... :	Age on Admission :	Wt. on Admission (grams) :
Date and Time of Discharge	...../...../20.....	Age on Discharge :	Wt. on Discharge (grams) :
Type of Admission	Inborn / Out born (Health Facility Referred) / Out born (Community Referred)		
Place of Delivery	Home / Ambulance/ Pvt. Hospital / Govt. Hospital (Name) :		
Referred From		Mode of Transport : Self Arranged / Govt. Provided	

Indication for Admission (⬭ Encircle the most relevant single indication, If multiple indication also mention all relevant numbers in the end as per priority, mention even if admitting for stabilization)

1. Prematurity <34 weeks
2. Low Birth Weight <1800 gm.
3. Perinatal Asphyxia
4. Neonatal Jaundice
5. Resp. Distress (Rate>60 or Grunt / Retractions)
6. Large Baby (>4 Kg. at 40 weeks)
7. Refusal to Feed
8. Central Cyanosis
9. Apnea / Gasping
10. Neonatal Convulsions
11. Baby of Diabetic mother
12. Oliguria
13. Abdominal Distension
14. Hypothermia <35.4 ºC
15. Hyperthermia >37.5 ºC
16. Hypoglycemia <45 mg%
17. Shock : Cold Periphery with CFT >3 sec & Weak Fast Pulse
18. Meconium Aspiration
19. Bleeding
20. Diarrhoea
21. Major Congenital Malformation
22. Unconsciousness
23. Any Other (.....)
24. **Multiple Indication** - Mention All Relevant Numbers: a ..... b ..... c ..... d .....

Provisional Diagnosis:

***Presumptive Diagnosis** (⬭ Encircle the most relevant single diagnosis, If multiple causes also mention all relevant numbers in the end as per sequence)

- Other LBW (1000 gm – 2499 gm) : P 07.1
- Prematurity (28-<37 Weeks) : P 07.3
- Small for Gestational Age (IUGR) : P 05.1
- RDS of Newborn (HMD) : P 22.0
- Transient Tachypnoea of Newborn : P 22.1
- Acquired Pneumonia : J 15
- Birth Asphyxia : P 21.0
- HIE of Newborn : P 91.6
- Neonatal Sepsis : P 36.9
  Meningitis : G 00
  Convulsions of Newborn : P 90
  (Hypoxic, Hypoglycaemic, Hypocalcaemic, CNS Infections, Birth Trauma, Metabolic, Other, Unknown Cause)
- Neonatal Jaundice : P 59
- Neonatal Diarrhoea : A 09
- Hypothermia of Newborn : P 80
- Environmental Hyperthermia of Newborn : P 81.0
- Congenital Malformation :
  (a) Cong. Hydrocephalus : Q 03
  (b) Meningomyelocele : Q 05
  (c) Imperforate anus : Q 42.3
  (d) Cleft Palate : Q 35
  (e) Cleft Lip : Q 36
  (f) Cleft Palate with Cleft Lip : Q 37
  (g) Congenital Deformities of Hip : Q 65
  (h) Congenital Deformities of Feet : Q 66
  (i) Other Malformation (.....)
- Any Other Diagnosis (..... .....)
- **Multiple Diagnosis-** Mention All Relevant Codes : a ..... b ..... c ..... d .....

* (Based on WHO, ICD - 10 Version: 2010)

This Sheet has to be filled on Admission by Doctor on Duty

MOTHER'S INFORMATION : Past History, ANC Period and During Labour

Mother's Age …….. Yrs. Mother's Wt ……..…..Kgs. Age at Marriage…….Yrs.

Birth Spacing: < 1 Yr / 1-2 Yr / >2-3 Yr / > 3 Yr / Not Applicable

Gravida :……..... Para :……..... Live Birth :……..... Abortion: …….....

LMP : ...../...../..... EDD : ...../...../..... Gestation Weeks : …….....

Antenatal Visit's : None / 1 / 2 / 3 / 4 T.T. Doses : None / 1 / 2

Hb : ……..... Blood Group : ….....

PIH : No [ ] Yes [Hypertension / Pre Eclampsia / Eclampsia]

Drug : No [ ] Yes [ ] (.....)

APH : Yes [ ] No [ ] GDM : Yes [ ] No [ ]

VDRL : Not Done / + Ve / -Ve HbsAg : Not Done / + Ve / -Ve

HIV Testing : Done / Not Done

Antenatal Steroids : Yes [ ] No [ ] If Yes, Dexamethasone [ ]

No. of doses : [1] [2] [3] [4] Foul Smelling Discharge : Yes [ ] No [ ]

Leaking P.V. > 24 Hours. : Yes [ ] No [ ] PIH : Hypertension / Pre Eclampsia / Eclampsia

Course of Labour : Uneventful / Prolonged 1st stage / Prolonged 2nd stage / Obstructed

E/O Feotal Distress : Yes [ ] No [ ] Type of Delivery : LSCS / AVD / NVD

Indication for Caesarean, if Applicable : [Cephalo Pelvic Disproportion] [Malpresentation] [Placenta Previa] [Obstructed Labor] [Foetal Distress] [Prolonged Labour] [Cord Prolapse] [Failed Induction (Dystocia)] [Previous LSCS] [Other .....]

Delivery Attended by : [Doctor] [Nurse] [ANM] [Dai] [Relative] [Any Other]……..

Other Significant Information :

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No [ ]"

BABY'S INFORMATION: At Birth

Cried Immed. after Birth : Yes [ ] No [ ] Wt. at Birth: …….…….. Kgs.

Gestational age : ..... in completed weeks Maturity : Preterm (<37 Wk) / Full term / Post term (≥42 Wk)

Resuscitation Required : NO [ ] Yes [ ] Tactile Stimulation /Only Oxygen / Bag & Mask [Duration.....min.]/ Intubation / Chest Compression / Adrenaline

Vitamin K Given : Yes [ ] No [ ] Breast Fed within 1 Hour : Yes [ ] No [ ]

BABY'S INFORMATION : On Admission

PRESENTING COMPLAINTS:

GENERAL EXAMINATION

General Condition : [Alert] [Lethargic] [Comatose] Temperature ……..ºC Heart Rate……/min

Apnea : Yes [ ] No [ ] RR ……/min.

Grunting : Yes [ ] No [ ] Chest Indrawing : Yes [ ] No [ ]

Head Circumference : ……c.m.

Color : Pink / Pale / Central Cyanosis / Peripheral Cyanosis

CRT >3 secs : Yes [ ] No [ ] Skin pinch > 2 secs : Yes [ ] No [ ]

Cry : Absent / Feeble / Normal / High Pitch

Tone : Limp / Active / Increase Tone Convulsions : Present on Admission / Past History / No

Jaundice : Yes [ ] No [ ] If Yes, extent [Face] [Chest] [Abdomen] [Legs] [Palms / Soles]

Bleeding : Yes [ ] No [ ] If Yes ,specify site [Skin] [Mouth] [Rectal] [Umbilicus]

Bulging Anterior Fontanel : Yes [ ] No [ ] Taking Breast Feeds : Yes [ ] No [ ]

Sucking : [Good] [Poor] [No Sucking] Attachment : [Well attached] [Poorly attached] [Not attached]

Umbilicus : [Red] [Discharge] [Normal] Skin Pustules : [No] [Yes <10] [Yes >=10] [Abscess]

Congenital Malformation : No [ ] Yes [ ] Hydrocephalus / M.M.C. / Imperforate Anus / Cleft Palate / Cleft Lip / Cleft Palate with Cleft Lip /Cong. Deformity of Hip / Cong. Deformity of Feet / Other.....

Blood Sugar : ……. Oxygen Saturation :…….....

Other Significant Information :

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No [ ]"

SYSTEMIC EXAMINATION

CVS : .....

RESPIRATORY : .....

PER ABDOMEN : .....

CNS : .....

OTHER SIGNIFICANT FINDING : .....

TREATMENT ADVISED : On Admission

INVESTIGATIONS ADVISED : On Admission

Doctor's Name and Signature

सहमति पत्र

हमें डॉक्टर द्वारा बता दिया गया है कि हमारा शिशु गंभीर रूप से बीमार है एवं उपचार के दौरान होने वाली जटिलताओं से हमें अवगत करा दिया गया है तथा हमें पूर्ण रूप से विदित है कि उपचार के दौरान समस्याऐं उत्पन्न हो सकती हैं। इन सभी खतरों से अवगत होने के बादा भी हम हमारे बच्चे को नवजात शिशु स्थिरीकरण इकाई (एन.बी.एस.यू.) में उपचार हेतु भर्ती कराने के लिये सहमत हैं।

Foot Print of Newborn
(Left Foot)

अभिभावक के हस्ताक्षर

FINAL OUTCOME

Successfully Discharged / Left Against Medical Advice / Referred / Expired

In Case of Death : Mention Cause of Death (✓ The Most Relevant Cause of Death)

1. Respiratory Distress Syndrome
2. Meconium Aspiration Syndrome
3. HIE / Moderate-Severe Birth Asphyxia
4. Sepsis
5. Pneumonia
6. Meningitis
7. Major Congenital Malformation
8. E.L.B.W. (Wt. less than 1000g)
9. Prematurity (<28 weeks of Gestation)
10. Neonatal Tetanus
11. Cause not established
12. Any Other : .....

.....

.....

This Sheet has to be filled on Admission by Doctor on Duty