SPECIAL NEW BORN CARE UNIT

DISCHARGE CARD

SNCU Reg. No.....

Doctor In charge.....

MCTS No.

Baby of (Mother's Name)			Sex:
Father's Name			Category:
Complete Address with Village Name / Ward No.			Date of Birth:
Contact No. & Relation	1.	2.	
Date and Time of Admission		Age on Admission :	Wt. on Admission (Kg) :
Date and Time of Discharge		Age on Discharge :	Wt. on Discharge (Kg) :
Place of Delivery		Type of Admission :	
Indication for Admission			
Final Diagnosis			
Final Outcome			

PRESENTING COMPLAINTS :

MOTHER'S INFORMATION : Past History and ANC Period

(Put Same as in Case Record Sheet)

Mother's Age : _____Yrs. Mother's Wt. :_____Kgs. Age at Marriage :_____Yrs. Consanguinity :_____

Birth Spacing :_____ L.M.P. :_____ E.D.D.:_____ Antenatal Visit's :_____

T.T. Doses :_____ Gestation Weeks :_____ Gravida :_____ Para :_____

Live Birth :_____ Abortion :_____ Hb :_____ Blood Group :_____

PIH :_____ Drug:_____ Radiation :_____ Illness :_____

APH :_____ GDM _____ Thyroid :_____ VDRL :_____

HbsAg :_____ HIV Testing :_____ Amniotic Fluid Volume :_____

Any Other Significant History :

This Card has to be filled on Discharge by Doctor on Duty

MOTHER'S INFORMATION : During Labour

(Put Same as in Case Record Sheet)

Antenatal Steroids :_____ Number of Doses :_____ Time Between Last Dose & Delivery :_____

Foul Smelling Discharge :_____ Uterine Tenderness :_____ Leaking P.V. > 24 Hours :_____

H/O Fever :_____ PPH :_____ PIH :_____

Amniotic Fluid :_____ Presentation :_____ Labor :_____

Course of Labor :_____ E/O Feotal Distress:_____ Type of Delivery :_____

Indication for Caesarean, if Applicable [_____] Delivery Attended by :_____

BABY'S INFORMATION : At Birth

(Put Same as in Case Record Sheet)

Cried Immed. after Birth :_____ Wt. at Birth :_____Kgs. Gestational Age_____(in completed weeks)

Maturity :_____ APGAR at 1 Min :_____ APGAR at 5 Min :_____

Resuscitation Required :_____ Vitamin K Given :_____ Breast Fed within 1 Hour :_____

BABY'S INFORMATION : On Admission

(Put Same as in Case Record Sheet)

GENERAL EXAMINATION

General Condition :_____ Temperature :_____ºC Heart Rate :_____/min Apnea:_____ RR :_____/min

B.P. :_____ Grunting :_____ Chest Indrawing :_____ Head Circumference :_____c.m.

Length :_____c.m. Color :_____ Cry :_____ CRT > 3 secs : _____

Skin pinch > 2 secs :_____ Meconium Stained Cord :_____ Tone :_____ Convulsions :_____

Jaundice :_____ Bleeding :_____ Bulging Anterior Fontanel :_____ Taking Breast Feed :_____

Sucking :_____ Attachment :_____ Umbilicus :_____ Skin Pustules :_____

Congenital Malformation :_____ Blood Sugar :_____ Oxygen Saturation :_____

SYSTEMIC EXAMINATION

CVS : .....

RESPIRATORY : .....

PER ABDOMEN : .....

CNS : .....

OTHER SIGNIFICANT FINDING : .....

This Card has to be filled on Discharge by Doctor on Duty

TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Step-Down : Yes / No (If yes duration.....)
4. KMC : Yes / No (If yes duration.....)
5. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)	.....	.....
b)	.....	.....
c)	.....	.....
d)	.....	.....

- .....
- .....
- .....
- .....
- .....

COURSE DURING TREATMENT

RELEVANT INVESTIGATIONS

CONDITION ON DISCHARGE

IMMUNIZATION STATUS

RI Card ☐ BCG ☐ OPV (0 Dose) ☐ Hepatitis B (Birth Dose) ☐

TREATMENT ADVISED ON DISCHARGE

1. Exclusive Breast Feeding till 6 months of Age.
2. Burp well after feed.
3. Maintain Temperature.
4. Immunization as per Schedule.
5. Follow-up as per Schedule.

- .....
- .....
- .....
- .....
- .....

Doctor's Name and Signature

This Card has to be filled on Discharge by Doctor on Duty

Institutional Follow up at S.N.C.U.

Visit	Anthropometry	Immunization Status	Examination Findings	Advice
8 Days Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Systemic :	Seen by.....
1 Month Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic :	Seen by.....
3 Months Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
6 Months Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
1 Year Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.) ..... M.U.A.C. (mm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....

This part has to be filled on follow-up by Doctor on Duty