# Section II

**Tracking of Pregnant Women** 



### Tracking of Pregnant Women

1	2	3	4	5			6		7
				Tappito of John Statement Broads  For office Statement Broads  See Statement Broads  For	Pass Book		JSY Beneficiary Do		Page Number <sup>1</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>2</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	

<sup>1</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
2 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Pepadro of India  The origin  The original or	Pass Book		JSY Beneficiary D		Page Number <sup>3</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>4</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	

<sup>3</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
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4 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				People of Inde  The draw (set hate)  The draw (set hate)	Pass Book		JSY Beneficiary D	etails	Page Number <sup>5</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>6</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>5</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
6 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadde of India  Teachure  Teachure	Pass Book		JSY Beneficiary D	etails	Page Number <sup>7</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>8</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>7</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
8 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadas of Inda  The officer  See Trans.  The officer  Th	Pass Book		JSY Beneficiary D	etails	Page Number <sup>9</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>10</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>9</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
10 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadde of India  Teachure  Teachure	Pass Book		JSY Beneficiary D	etails	Page Number <sup>11</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>12</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>11</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
12 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadis of India  Teaching  Include  See Affect  See A	Pass Book		JSY Beneficiary D	etails	Page Number <sup>13</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>14</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>13</sup>PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
14ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadis of India  Text dissort  Name  Anne  Name  Name	Pass Book		JSY Beneficiary D	etails	Page Number <sup>15</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>16</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>15</sup> PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
16 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Papadis of India  Text Class  See Affect  No. Text Class  No.	Pass Book		JSY Beneficiary D	etails	Page Number <sup>17</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>18</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>17</sup>PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
18ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

1	2	3	4	5			6		7
				Deputie of Inda  The of horse  See district  See district	Pass Book		JSY Beneficiary Details		Page Number <sup>19</sup>
Sr. No.	MCTS ID No. of Pregnant Woman <sup>20</sup>	Name of Pregnant Woman	Name of Husband*	Aadhaar No. / NA	Bank Account No. / NA	Name of Bank & Branch / NA	JSY Beneficiary Yes/No.	Payment Received (Yes/No)	
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<sup>19</sup>PAGE NUMBER OF THIS REGISTER (ON WHICH DETAILS OF PREGNANT WOMEN ARE RECORDED)
\*IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE
NA- NOT AVAILABLE
20 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

#### **General Information**













				1 1 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman21	Name of Pregnant Woman	Address	Name of Husband22	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration
1.											
2.											
3.											
4.											

<sup>21</sup>SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I 22IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

#### **General Information**







13	14	15	16 EDD <sub>0</sub>	17	18 Past H/O		19			20 Indicate	21 VDRL (RPR)
of pregnan at the time registration	ks cy within 12 of weeks of pregnancy (Yes/No)	PW (KG) at		Blood Group of PW [Done (Result)/ Not Done]	Illness¤		Past Obstetrics Hiptorial No. of Details of last two regnancy Pregnancy		Outcome of Pregnancy	expected place and	test done (date) + VE/VE / Not done
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>155</sup> 

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## **Tracking of Pregnant Women**

Ante	Natal	Care	(ANC	) Details
,				,

23	24	25	26	27	28	29	30	)	31	32	,	33
Sr. No.		Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of	Abortic No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of	If induced,	Wt. of PW (Kg)	BP mi		Hb (gm%)
							weeks of pregnancy	indicate facility (Govt./Pvt.)				
		1st visit						,				
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
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		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETV WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details



	<					hok	
	3	4	3	35	3	86	
		Test ot Done)		ugar Test ot Done)	(Date)		
Albui (P/	min A)	Sugar <sup>(3)</sup> (P/A)	If done Fasting	If done Post Prandial	Ist	2nd / Boost er	

No. of	Folic
Acid 7	Tabs**
(withir	າ 12
weeks	of
pregn	(4)
ancy)	<sup>(4)</sup> / Nil
given	23 24

	38			39		40	41				
ic **	No of IFA	F		domen exami		Any	Date, type &	Maternal death	If died, date, place &		
2 of	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal heart rate	presentation	Foetal movements (Normal/Increased/ Decreased/ Absent)	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable cause <sup>(8)</sup>		
•											
•											
-											

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 24 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

# **Tracking of Pregnant Women**

PW - 3







43

45

46

47

48

49

50

51

Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>25</sup>	Who Conducted Delivery <sup>26</sup>	Type of Deliver <sup>27</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)		Time of titutional Delivery) Time (HH:MM)
								(22/1111111111)	

<sup>25</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>26</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>27</sup> NORMAL / CAESAREAN / ASSISTED

<sup>28 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>30</sup> (G	ven/Not G	iven)
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at	started within one	OPV	BCG	HEP B	VIT K <sup>31</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illialit (Wi/F)	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>29</sup>	birth (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>29 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 30 AT THE TIME OF BIRTH 31 INJ. VITA ABUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5mg) NA - NOT APPLICABLE

65	66	67	68	69	70	71	72	
Sr. No.	Name of Mother			Post Natal C	Care (PNC)			
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to		Indicate danger Sign(s) (If any)		
		Delivery <sup>32</sup>		mother/Nil	Mother <sup>33</sup>	Infant <sup>34</sup>	Weight of infant <sup>35</sup> (Kg)	
		1st Day						
		3rd Day						
		7th Day						
		42 nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						

<sup>32</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>33 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>34 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>35</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used	raception in died, date		bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

### Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE (	HBNC) THREE MORE VISIT	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	QUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (I	PNC)		
		PNC Visit <sup>36</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>37</sup>	Infant <sup>38</sup>	Weight of infant <sup>39</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day 14th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY

(A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

(A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASEI

<sup>38 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>39</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

	UNDER HOME BASED NEV	VBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELIV	VERY ARE REQUIRED	
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used 41	If died, date and pro Infant Death <sup>42</sup>	bable cause of death  Mother Death <sup>43</sup>	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>40 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>41 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>42</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>43</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.

#### **General Information**













				11 1 7 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman44	Name of Pregnant Woman	Address	Name of Husband45	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration
5.											
6.											
7.											
8.											

#### **General Information**







											_
13	14	15	16	17	18	19		20	21		
No. of weeks of pregnancy at the time of	Registered	Weight of	EDD <sup>(1)</sup>		Past H/O	Past Obstetric	s History		Indicate expected	VDRL (RPR) test done	
registration	nregnancy	PW (KG) at the time of registration		Blood Group of PW [Done (Result)/ Not Done]		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done	
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>164</sup> 

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-II**

# Tracking of Pregnant Women

PW - :

INDUCED

·			1	Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortio	on (if any) <sup>(2)</sup>		Wt. of BP m		mm Hg (gm <sup>o</sup>	
			7.11.0	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

/SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

d			3	9			
3	4	3	35		36	37	
Urine Test (Done/Not Done)		Blood Some/No	ugar Test ot Done)		Dose Date)	No. of	
Albumin (P/A)		If done Fasting	If done Post Prandial	Ist	2nd/ Booster	Tabs** (within 12 wee ks (4)/ Nil	
			Prandiai			of	
						pregnanc	
						y) given 46	



37	38			39		40	41	4	12
of C Acid bs**	No of IFA Tabs given	F Fundal	Foetal	doman examil Foetal presentation	Foetal movements	Any symptom of high risk <sup>(6)</sup>	Date, type & name of	Maternal death (No/Yes)	If died, date, place & probable cause (8)
	/ Nil 12 weeks) <sup>(5)</sup> Size of the uterus		/Position	(Normal/Increa sed/ Decreased/	please indicate	referral facility <sup>(7)</sup>		<b></b>	
gnanc iven <sup>46</sup>									
ı						l	<u> </u>		

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

# **Tracking of Pregnant Women**

PW - 3







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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>48</sup>	Who Conducted Delivery <sup>49</sup>	Type of Deliver <sup>50</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)		Time of titutional Delivery) Time (HH:MM)
								(==::::::::::::::::::::::::::::::::::::	

<sup>48</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>49</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>50</sup> NORMAL / CAESAREAN / ASSISTED

<sup>51 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

<u>.</u>	Infant Details											
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Birth Dose <sup>53</sup> (G ven/Not G iven)		
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	IIIIIIeulately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	НЕР В	VIT K <sup>54</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	mant (m/i )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>52</sup>	birtir (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

 <sup>(</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL
 AT THE TIME OF BIRTH
 INJ. VITAMIN K3- INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)</li>
 NA - NOT APPLICABLE

65	66	67	68	69	70	71	72		
Sr. No.	Name of Mother			Post Natal (	Post Natal Care (PNC)				
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to	Indicate danger				
		Delivery <sup>55</sup>		mother/Nil	Mother <sup>56</sup>	Infant <sup>57</sup>	Weight of infant <sup>58</sup> (Kg)		
		1st Day							
		3rd Day							
		7th Day							
		42 nd Day							
		1st Day							
		3rd Day							
		7th Day							
		42nd Day							
		1st Day							
		3rd Day							
		7th Day							
		42nd Day							
		1st Day							
		3rd Day							
		7th Day							
		42nd Day							

<sup>55</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>56 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>57 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>58</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died,		bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause Date Cause Da		Date	Transit)		

# **SECTION-II** Tracking of Pregnant Women

		NACE HOME DAGED NEW DODA OADE (	UDMO) TUDEE MODE WO	TO ON 4 (THE 04 OT 10 COTH)	NAV OF DELIVERY ARE DI	COURTE	
	U	NDER HOME BASED NEWBORN CARE (	HBNC) THREE MORE VISI	15 UN 141H, 2151 , & 281H L	DAY OF DELIVERY ARE K	EQUIRED	
		1					
82	83	84	85	86		87	
Sr. No.	No. of Maril			5 (11410 (1	7110)		
	Name of Mother	DNO 1/1-1/59 A (1-1) Dollars	Date of PNC Visit	Post Natal Care (	PNC)		
		PNC Visit <sup>59</sup> After Delivery	Date of PNC visit	No. 6154 Television	Indicate dange	r sign (s) (If any)	
				No. of IFA Tabs given to mother/Nil			62
				to mother/wii	Mother <sup>60</sup>	Infant <sup>61</sup>	Weight of infant <sup>62</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY

(A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>61 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>62</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

	UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED												
88		89	90	91	92	93							
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>64</sup>	If died, date and pro Infant Death <sup>65</sup>	bable cause of death  Mother Death	eath eath <sup>66</sup> Place of death (Home/Hospital/ In Transit)								
Mother	Infant												
	-	-											
	-	-											

<sup>63 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>64 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>65</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman67	Name of Pregnant Woman	Address	Name of Husband68	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







13 14	15	16	17	18	19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>	Past Obstetrics History				VDRL (RPR) test done
registration (Yes/No)	the time	me of	PW [Done (Result)/		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and name of facility for delivery <sup>(5)</sup>	(date) + VE/VE / Not done
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

# Tracking of Pregnant Women

	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of  weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	Wt. of PW (Kg)	BP mi Systolic	m Hg Diastolic	Hb (gm%)
		1st visit 2nd visit										
		3rd visit 4th visit										
		1st visit										
		2nd visit 3rd visit										
		4th visit										
		1st visit 2nd visit										
		3rd visit 4th visit										
		1st visit										
		2nd visit 3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

Second Part	d													
Urine Test (Done/Not Done) Blood Sugar Test (Done/Not Done) (Done/Not Done) (Done/Not Done) (Done/Not Done) (P/A) Sugar (P/A) Sugar (P/A)		24	25	26	37	20			20		40	44		10
Urine Test (Done/Not Done) (Do	•	<del>34</del>		30			F	undal/Ab		nation				
Albumin (P/A) Sugar (3) If done Post Prandial Probable (after 12 weeks) (5) Fraction (Albumin (P/A)) Fraction (P/A) Prandial Probable (after 12 weeks) (5) Fraction (Albumin (P/A)) Fraction (Albumin (P/A)) Fraction (P/A) Fraction (No/Yes) (No/Yes) Probable (No/Yes) Fraction (No/Yes) Probable (No/Yes) Fraction (No/Yes) Probable (No/Yes) Proba						Tabs Fundal Foetal Foeta			Foetal	F	symptom of	name of	death	place &
(P/A) (P/A) Fasting Post Prandial Booster (within 12 weeks)(5) Size of the uterus (After 12 weeks)(5) Size of the uterus (After 12 weeks)(5) Decreased/ Absent)					Tabs**	_							(No/Yes)	probable
Prandial ks (7 Nil of pregnanc Absent)	(P/A)	(P/A)			WOO	(atter	Size of the	rate	/Position			facility		cause
pregnanc Absent)					ks (*/ Nil		uterus				a.ca.c			
hegian sylvanis yn given is yn														
					y) given <sup>69</sup>					Absenty				
					70									
					_									
					-									
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					<u> </u> -									
					<u> </u> -									
			-		-									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY.

<sup>(4)</sup> TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY)

<sup>(5)</sup> TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF

IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)
TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

# **Tracking of Pregnant Women**

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PW - 3







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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>71</sup>	Who Conducted Delivery <sup>72</sup>	Type of Deliver <sup>73</sup>	Complication	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Discharge (If Ins	Time of titutional Delivery)
								(DD/MM/YYYY)	Time (HH:MM)

<sup>71</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>72</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>73</sup> NORMAL / CAESAREAN / ASSISTED

<sup>74 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

## **Tracking of Pregnant Women**

**PW - 3** 

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>76</sup> (G	ven/Not G	
Sr. No. of the	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately at birth	higher facility for further	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>77</sup>
baby		given to mother (Yes/No/Don't Know)	,	(Yes/No)	management (Yes/No/NA)	birth <sup>75</sup>	(-19)	(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>75 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 76 AT THE TIME OF BIRTH 77 INJ. VITA ABUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72			
Sr. No.	Name of Mother			Post Natal C	Post Natal Care (PNC)					
		PNC Visit after Delivery <sup>78</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>79</sup>	Sign(s) (If any) Infant <sup>80</sup>	Weight of infant <sup>81</sup> (Kg)			
		1st Day								
		3rd Day								
		7th Day								
		42 nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								

<sup>78</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>79 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>80 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>81</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died, o		bable cause of Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)	

# SECTION-II Tracking of Pregnant Women

							1 00 470
	U	INDER HOME BASED NEWBORN CARE (	HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE R	EQUIRED	
82	83	84	85	86		87	
		٥.	33			0.	
Sr. No.	Name of Mother			Post Natal Care (	DNC)		
	Name of Mother	PNC Visit <sup>82</sup> After Delivery	Date of PNC Visit	1 05t Hatai Gale	1110)		
		PNC VISIT After Delivery	Date of PINC VISIT		Indicate dange	r sign (s) (If any)	
				No. of IFA Tabs given	a.oato daiigo		
				to mother/Nil	Mother <sup>83</sup>	Infant <sup>84</sup>	Weight of infant <sup>85</sup>
							110191110111111111
		14th Day					
		·					
		04 / 10					
		21st Day					
		28th Day					
		14th Day					+
		,					
		21st Day					
		28th Day					
		14th Day					
		1 2 2,					
		21st Day					
		28th Day					
		28th Day					
		14th Day					
		21st Day					
		20th Day					
		28th Day		1			

<sup>82</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY

<sup>83 (</sup>A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>84 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>85</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED											
88		89	90	91	92	93					
If danger sign (s) present for a place & name of re		Indicate post partum contraception method being used <sup>87</sup>	If died, date and pro Infant Death <sup>88</sup>	If died, date and probable cause of death Infant Death <sup>88</sup> Mother Death <sup>89</sup>		Remarks (If any)					
Mother	Infant										

<sup>86 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>87 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>88</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>89</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman90	Name of Pregnant Woman	Address	Name of Husband91	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







13 14	15	16	17	18		19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>		Past H/O Illness <sup>(2)</sup>		Past Obstetric		Indicate expected	VDRL (RPR) test done	
registration (Yes/No)	the time	me of	PW [Done (Result)/ Not Done]			Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

22

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

# Tracking of Pregnant Women

PW - :

·	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortio	portion (if any) <sup>(2)</sup>		Wt. of BP mm H		m Hg	Hb (gm%)
			7.11.0	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

(2)

INDUCED

/SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

_	da			3												
	2	4		35		26	37	38			39		40	44		12
	ა	4		)		36		No of IFA Fundal/Abdoman examination		nation	40 Any	41 Date, type &	Maternal	If died, date,		
	Urine			ugar Test		Dose	No. of Folic Acid	Tabs	Fundal	Fastal	Fastal	Fastal	symptom of		death	place &
			(Done/No		lst	Date) 2nd/	Tabs**	given	Fundal Height/	Foetal	Foetal presentation	Foetal movements	high risk <sup>(6)</sup>	referral	(No/Yes)	probable
	(P/A)		If done Fasting			Booster	(within 12	(after	6.1		-	(Normal/Increa	please	facility <sup>(7)</sup>		(8) cause
		(1774)	doming	Post Prandial			wee ks (4)/ Nil	12 weeks) <sup>(5)</sup>	uterus			sed/	indicate			
				Tanda			of					Decreased/				
_							pregnanc					Absent)				
-							y) given 92									
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L					<u> </u>	l	J									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY.

<sup>(4)</sup> TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY )

<sup>(5)</sup> TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF

IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)
TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

# **Tracking of Pregnant Women**

PW - 3







43

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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>94</sup>	Who Conducted Delivery <sup>95</sup>	Type of Deliver <sup>96</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	Discharge (If Inst	Time of titutional Delivery)
								(DD/MM/YYYY)	Time (HH:MM)

<sup>94</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>95</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>96</sup> NORMAL / CAESAREAN / ASSISTED

<sup>97 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

_					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>99</sup> (G	ven/Not G	iven)
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	IIIIIIeulalely	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	НЕР В	VIT K <sup>100</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illiant (W/I )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>98</sup>	birtir (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>98 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 99 AT THE TIME OF BIRTH 100 INJ. VITABAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72
Sr. No.	Name of Mother			Post Natal (	Care (PNC)		
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to	Indicate danger	Sign(s) (If any)	
		Delivery <sup>101</sup>		mother/Nil	Mother <sup>102</sup>	Infant <sup>103</sup>	Weight of infant <sup>104</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>101</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>102 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 103 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

<sup>03 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK / MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>104</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used		If died, date and probable Infant Death Moth			Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

## Tracking of Pregnant Women

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	AY OF DELIVERY ARE R	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (I	PNC)		
		PNC Visit <sup>105</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange	r sign (s) (If any)	
				to mother/Nil	Mother <sup>106</sup>	Infant <sup>107</sup>	Weight of infant <sup>108</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day 14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>105</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
106 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>107 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>108</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

## Tracking of Pregnant Women

PW - 4 A

		Traokii	ig of Fregulatic Wolf			PW-4A
	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	E MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELI	VERY ARE REQUIRED	
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>110</sup>	rtum contraception Infant Death 111 Mother Death 112		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>109 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>110 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>111</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>112</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				1 . 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman113	Name of Pregnant Woman	Address	Name of Husband114	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

<sup>113</sup>SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I 114IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE







13 14	15	16	17	18	19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>	Past Obstetric		Indicate expected	VDRL (RPR) test done	
registration (Yes/No)	the time	me of	PW [Done (Result)/		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## **Tracking of Pregnant Women**

				Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Abortion (if any)		Abortion (if any)			Wt. of PW	BP m	m Hg	Hb (gm%)
			ANO	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

3	4	35		36		37
Urine (Done/N	e Test ot Done)	ugar Test ot Done)	тт	Dose Date) 2nd/ Booster	Та	o Acid bs** nin 12
					(	of gnanc giver





37	38			39		40	41	4	12
of	No of IFA	F	undal/Ab	doman exami	nation	Any	Date, type &		If died, date, place &
	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	roto	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	symptom of high risk <sup>(6)</sup> please indicate	name of referral facility <sup>(7)</sup>	(No/Yes)	probable cause (8)
of egnanc									
given									
16									
			•						

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

PW - 3







Sr. No.					Delivery Outco	me		
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>117</sup>	Who Conducted Delivery <sup>118</sup>	Type of Deliver <sup>119</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	Time of titutional Delivery) Time (HH:MM)
								•

<sup>117</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>118</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>119</sup> NORMAL / CAESAREAN / ASSISTED

<sup>120 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>122</sup> (G	ven/Not G	iven)
<b>2</b> 11 44	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteroids	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>123</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	mant (m/i )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>121</sup>	birtir (Ng)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>121 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 122 AT THE TIME OF BIRTH
123 INJ. VITABRIS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72			
Sr. No.	Name of Mother			Post Natal Care (PNC)						
		PNC Visit after Delivery <sup>124</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>125</sup>	Sign(s) (If any)	Weight of infant <sup>127</sup> (Kg)			
		1st Day					Weight of illiant (kg)			
		3rd Day								
		7th Day								
		42 nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day 42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								

<sup>124</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>125 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 126 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

<sup>26 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASE MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>127</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



74	75	76	77	78	79	80	81
mother or infant, indicate eferral facility	Indicate post partum contraception method being used					Place of death (Home/Hospital/ In	Remarks (If any)
Infant		Cause	Date	Cause	Date	Transit)	, , , ,
	mother or infant, indicate eferral facility	nother or infant, indicate partum contraception method being used	mother or infant, indicate partum contraception method being used If died, or infant.	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and promote infant Death	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and probable cause of Infant Death  Cause Date Cause	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and probable cause of death  Infant Death  Cause Date Cause Date	Indicate post partum contraception method being used  Indicate post partum contraception method being used  Indicate post partum contraception method being used  Infant Death Mother Death  Cause Date Cause Date  Cause Date

### SECTION-II

## Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	EQUIRED			
82	83	84	85	86	87				
Sr. No.	Name of Mother			Post Natal Care (I	PNC)				
		PNC Visit <sup>128</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)			
				to mother/Nil	Mother <sup>129</sup>	Infant <sup>130</sup>	Weight of infant <sup>131</sup>		
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							

<sup>128</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
129 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>130 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>131</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Traokii	ig of Fregulatic Wolf			PW-4A
	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	E MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELI	VERY ARE REQUIRED	
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>133</sup>	If died, date and pro Infant Death <sup>134</sup>	bable cause of death  Mother Death  135	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>132 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>133 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>134</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>135</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.

### **General Information**













				11 . 1							
1		3	4	5	6	7	8	9	10	11	12
S	MCTS ID No of Pregnant Woman136	Name of Pregnant Woman	Address	Name of Husband137	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18	19		20	21	
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>	Past Obstetrics History				VDRL (RPR) test done
registration (Yes/No)	the time	me of	PW [Done (Result)/		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	expected place and name of facility for delivery <sup>(5)</sup>	(date) + VE/VE / Not done
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-M**

# Tracking of Pregnant Women

PW - 2

1	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	29 30			32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic No	ortion (if any) <sup>(2)</sup>		Wt. of PW	BP mi	n Hg	Hb (gm%)
				ANC done	pregnancy		If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)
INDUCED
20!

#### Ante Natal Care (ANC) Details

de			3	P		
3	4	3	35		36	37
(Done/N		(Done/No	ugar Test ot Done)	(E	Dose Date)	No. of Folic Acid Tabs**
Albumin (P/A)	Sugar <sup>(3)</sup> (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster	(within 12 wee ks
						of pregnanc y) given



37	38			39	40	41	12
	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal	doman examing Foetal presentation /Position	high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>	If died, date, place & probable cause (8)
of gnanc given							

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

139 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

48

PW - 3







43

44

45

46

47

49

50

Sr. No.			,		Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>140</sup>	Who Conducted Delivery <sup>141</sup>	Type of Deliver <sup>142</sup>	Complication	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery		Delivery	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)

<sup>140</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>141</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>142</sup> NORMAL / CAESAREAN / ASSISTED

<sup>143 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

					Infant Deta	ails				145		
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>145</sup> (G	ven/Not G	
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	HEP B	VIT K <sup>146</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illiant (W/I )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>144</sup>	birtir (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>144 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER (SPECIFY), (H) NIL 145 AT THE TIME OF BIRTH

146 INJ. VIATABRIS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72
Sr. No	. Name of Mother			Post Natal C			
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to	Indicate danger	Sign(s) (If any)	
		Delivery <sup>147</sup>		mother/Nil	Mother <sup>148</sup>	Infant <sup>149</sup>	Weight of infant <sup>150</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>147</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 148 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>149 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>150</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81						
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died, o		Mother Death								Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)							

### SECTION-II

## Tracking of Pregnant Women

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH D	AY OF DELIVERY ARE RI	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (F	PNC)		
		PNC Visit <sup>151</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange	r sign (s) (If any)	
				to mother/Nil	Mother <sup>152</sup>	Infant <sup>153</sup>	Weight of infant <sup>154</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day 14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>151</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
152 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>153 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>154</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Hackii	ig of Fregulatic Wolf			PW-4A
	UNDER HOME BASED NE	WBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DEL	VERY ARE REQUIRED	
8	8	89	90	91	92	93
	or mother or infant, indicate referral facility <sup>155</sup>	Indicate post partum contraception method being used <sup>156</sup>	If died, date and pro Infant Death <sup>157</sup>	bable cause of death  Mother Death  158	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					
			Ī.			

<sup>155 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>156 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>157</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>158</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.

### **General Information**













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman159	Name of Pregnant Woman	Address	Name of Husband160	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18		19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>		Past Obstetrics History			Indicate expected	VDRL (RPR) test done
registration (Yes/No)	the time	me of	PW [Done (Result)/			Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-II**

## **Tracking of Pregnant Women**

	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic	on (if any) <sup>(2)</sup>		Wt. of PW	BP m	m Hg	Hb (gm%)
			ANO	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)
INDUCED
21!

#### Ante Natal Care (ANC) Details

ded			3			
3	4	3	35	36		37
(Done/N	e Test ot Done) Sugar <sup>(3)</sup> (P/A)	Blood So (Done/No If done Fasting	, , , , , , , , , , , , , , , , , , ,	Dose Date) 2nd/ Booster	Tal	of Acid bs** in 12
					preg	of Inanc given



37	38			39		40	41	4	death place &	
of c Acid	No of IFA	F		doman exami		Any	Date, type &	Maternal death		
bs** nin 12	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable	
of		uterus			Decreed					
gnanc										
given										

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)
TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME

OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 162 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

PW - 3







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Sr. No.					Delivery Outco	me		
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>163</sup>	Who Conducted Delivery <sup>164</sup>	Type of Deliver <sup>165</sup>	Complication	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Time of titutional Delivery) Time (HH:MM)

<sup>163</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>164</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>165</sup> NORMAL / CAESAREAN / ASSISTED

<sup>166 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

					Infant Deta	ails				459		
	Full term/ Preterm	If preterm delivery ( >24 weeks & < 34 weeks)		Baby cried	Referred to	Any	W	Breast feeding	Birth	Dose <sup>168</sup> (G	ven/Not G	
Sr. No. of the	rotom	inj. corticosteroids	nj. corticosteroids infant (M/F)	immediately at birth	101 Tartifici	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>169</sup>
baby		given to mother (Yes/No/Don't Know)		(Yes/No)	management (Yes/No/NA)	birth		(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>167 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 168 AT THE TIME OF BIRTH
169 INJ. VITAMIN K3- INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5mg)
NA - NOT APPLICABLE

6	66	67	68	69	70	71	72
Sr. I	o. Name of Mother	Post Natal Care (PNC)					
		PNC Visit after Delivery <sup>170</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>171</sup>	Sign(s) (If any) Infant <sup>172</sup>	Weight of infant <sup>173</sup> (Kg)
		1st Day					Weight of mant (rtg)
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>170</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)
171 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>172 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>173</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for mother or infant, indicate place & name of referral facility		Indicate post partum contraception method being used	If died, date and prob		bable cause of death  Mother Death		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

## Tracking of Pregnant Women

PW - 4 A

	U	NDER HOME BASED NEWBORN CARE (	HBNC) THREE MORE VISIT	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	QUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (	PNC)		
		PNC Visit <sup>174</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>175</sup>	Infant <sup>176</sup>	Weight of infant <sup>177</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>174</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY

<sup>175 (</sup>A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMÍNAL PÁIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>176 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>177</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Haokii	ig of thegriant won	1011		PW - 4 A						
	UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED											
88	· · · · · · · · · · · · · · · · · · ·	89	90	91	92	93						
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>179</sup>	If died, date and pro Infant Death <sup>180</sup>	bable cause of death  Mother Death  **Tender Death************************************	Place of death (Home/Hospital/ In Transit)	Remarks (If any)						
Mother	Infant											

<sup>178 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>179 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>180</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>181</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman182	Name of Pregnant Woman	Address	Name of Husband183	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18		19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>		Past Obstetrics History			Indicate expected	VDRL (RPR) test done
registration (Yes/No)	the time	me of	PW [Done (Result)/	Total No. of De		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## SECTION-M

# Tracking of Pregnant Women

PW - :

				Ante N	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	0	31	3	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)		Wt. of PW (Kg)	BP m Systolic	BP mm Hg (6	Hb (gm%)
							No. of weeks of pregnancy	abortion indicate facility (Govt./Pvt.)				
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

22.1

#### Ante Natal Care (ANC) Details

	4		35	P	3	
ა	4	3	ວວ			
	Test ot Done)	Blood Si (Done/No	ugar Test ot Done)	TT (E	No. Folic	
Albumin (P/A)	Sugar <sup>(3)</sup> (P/A)	If done Fasting	If done Post	Ist	2nd/ Booster	Tab (with) wee
			Prandial			ks
						C
						preg
						<b>y)</b> 184 185
	I	I			1	





				1						
	37	38			39		40	41	4	12
er	No. of Folic Acid Tabs** (within 12 wee	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the	Foetal	doman examing Foetal presentation /Position		high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>		If died, date, place & probable cause (8)
	ks (*// Nil	12 Weeks)	uterus			Decreed!	illuicate			
	pregnanc									
	y) given									
	104 105									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY.

<sup>(4)</sup> TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY)

<sup>(5)</sup> TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF

IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME

OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 185 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

PW - 3







Sr. No.			'		Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>186</sup>	Who Conducted Delivery <sup>187</sup>	Type of Deliver <sup>188</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	Discharge (If Inst	Time of titutional Delivery)
								(DD/MM/YYYY)	Time (HH:MM)

<sup>186</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>187</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>188</sup> NORMAL / CAESAREAN / ASSISTED

<sup>189 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/ Preterm	If preterm delivery ( >24 weeks & < 34 weeks)		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>191</sup> ദ്ര	ven/Not G	
Sr. No. of the	rieteilli	inj. corticosteriods	Sex of infant (M/F)	IIIIIIIeuialeiy	higher facility for further	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>192</sup>
baby		given to mother (Yes/No/Don't Know)	` ′	(Yes/No)	management (Yes/No/NA)	birth <sup>190</sup>	· · · · · · · · · · · · · · · · · · ·	(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>190 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 191 AT THE TIME OF BIRTH
192 INJ. VITABBUS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

6	66	67	68	69	70	71	72			
Sr.	No. Name of Mother			Post Natal Care (PNC)						
		PNC Visit after Delivery <sup>193</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger	Indicate danger Sign(s) (If any)  Mother <sup>194</sup> Infant <sup>195</sup>				
					Wother	mant	Weight of infant <sup>196</sup> (Kg)			
		1st Day								
		3rd Day								
		7th Day								
		42 nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								

<sup>193</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>194 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 195 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>196</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died, o		Mother Death		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

## Tracking of Pregnant Women

PW - 4 A

	U	NDER HOME BASED NEWBORN CARE (	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	AY OF DELIVERY ARE RE	QUIRED				
82	83	84	85	86	87					
Sr. No.	Name of Mother			Post Natal Care (I	PNC)					
		PNC Visit <sup>197</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)				
				to mother/Nil	Mother <sup>198</sup>	Infant <sup>199</sup>	Weight of infant <sup>200</sup>			
		14th Day								
		21st Day								
		28th Day								
		14th Day								
		21st Day								
		28th Day								
		14th Day								
		21st Day								
		28th Day								
		14th Day								
		21st Day								
		28th Day								

<sup>197</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY

<sup>198 (</sup>A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMÍNAL PÁIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>199 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>200</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

	PW - 4 A											
UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED  88 89 90 91 92 93												
8	8	89	90	91	92	93						
If danger sign (s) present for place & name of		Indicate post partum contraception method being used 202	If died, date and probable cause of death Infant Death <sup>203</sup> Mother Death <sup>204</sup>		Place of death (Home/Hospital/ In Transit)	Remarks (If any)						
Mother	Infant											

<sup>201 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>202 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>203</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>204</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman205	Name of Pregnant Woman	Address	Name of Husband206	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







										_		
13	14	15	16	17	18		19			20	21	
No. of weeks	Registered	Weight of			Past H/O		Past Obstetrics History				VDRL (RPR) test done	
registration	pregnancy	PW (KG) at the time of		(Result)/		Total No. of				place and	(date) + VE/VE / Not done	(
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
(	13 No. of weeks of pregnancy at the time of registration	No. of weeks of pregnancy within 12 weeks of registration	No. of weeks of pregnancy within tegistration to the time of pregnancy weeks of pregnancy pregnancy the time of pregnancy the time of tegistration to the time of the	13  14  15  16  No. of weeks of pregnancy within weeks registration  12  Weight of PW (KG) at the time of pregnancy of pregnancy registration	13  14  15  16  17  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy	13  14  15  16  17  18  No. of weeks of pregnancy within at the time of registration  12  Weight of PW (KG) at the time of pregnancy of	13  14  15  16  17  18  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy  Weight of PW (KG) at the time of pregnancy  Total No. of Pregnancy  Past H/O Blood Group of PW [Done (Result)/ Pregnancy	No. of weeks of pregnancy at the time of registration registration (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of registration (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of Past H/O (Illness(2))  Total No. of Past Obstetric (Yes/No)  Last Preg  Last to Last Preg  Last to Last Preg  Last to Last Preg	No. of weeks of pregnancy (Yes/No)  No. of weeks pegistred within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of Weight of PW (KG) at the time of registration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of No. of Past H/O Past Obstetrics History  Total No. of Details of last two Complications (3)  Last Preg  Last to Last Preg	No. of weeks of pregnancy within registration of registration of pregnancy (Yes/No)  Registered within 12 (Weight of pregnancy (Yes/No)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Result)/ (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Result)/ (	No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pw (KG) at the time of pregnancy of the time of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pw (KG) at the time of pregnancy of the time of pregnancy of pregnancy (No)  No. of weeks of pregnancy of pw (KG) at the time of pw (KG) at the time of pregnancy of the time of pregnancy of pw (No)  No. of weeks of pregnancy of pw (KG) at the time of the time o	No. of weeks of pregnancy registration of the time of pregnancy (Yes/No) of the time of th

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HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-M**

# Tracking of Pregnant Women

PW - :

	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29 30		)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortion (if any) <sup>(2)</sup>		Wt. of PW	BP mi	n Hg	Hb (gm%)	
				ANC done	pregnancy	NO	If Yes, (I/S) No. of	If induced, abortion	(Kg)	Systolic	Diastolic	
							weeks of	indicate facility				
		1st visit					pregnancy	(Govt./Pvt.)				
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

INDUCED
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#### Ante Natal Care (ANC) Details

de			3	9				
3	4	3	35		36	37		
Urine (Done/N	Test ot Done)		ugar Test ot Done)		Dose Date) 2nd/ Booster	ks (4)/ Ni		
						of pregna y) gi	anc ven	



37	38			39		40	41	4	12
of	No of IFA	F	undal/Ab	doman exami	nation	Any	Date, type &		If died, date, place &
c Acid bs** nin 12	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable (8) cause
of gnanc									
given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 | jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

208 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

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PW - 3







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Sr. No.					Delivery Outco	me		
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>209</sup>	Who Conducted Delivery <sup>210</sup>	Type of Deliver <sup>211</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	Time of titutional Delivery) Time (HH:MM)

<sup>209</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>210</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>211</sup> NORMAL / CAESAREAN / ASSISTED

<sup>212 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails				344		
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>214</sup> (G	ven/Not G iven)	
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	HEP B	VIT K <sup>215</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	imant (W/i )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>213</sup>	birtii (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>213 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 214 AT THE TIME OF BIRTH 215 INJ. VITABAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72
Sr. N	o. Name of Mother			Post Natal C	Care (PNC)		
		PNC Visit after Delivery <sup>216</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil		Indicate danger Sign(s) (If any)  Mother <sup>217</sup> Infant <sup>218</sup>	
							Weight of infant <sup>219</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>216</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 217 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>218 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>219</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



74	75	76	77	78	79	80	81
mother or infant, indicate eferral facility	Indicate post partum contraception method being used					Place of death (Home/Hospital/ In	Remarks (If any)
Infant		Cause	Date	Cause Date		Transit)	, , , ,
	mother or infant, indicate eferral facility	nother or infant, indicate partum contraception method being used	mother or infant, indicate partum contraception method being used If died, or infant.	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and promote infant Death	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and probable cause of Infant Death  Cause Date Cause	Indicate post partum contraception method being used  Indicate post partum contraception method being used  If died, date and probable cause of death  Infant Death  Cause Pate Cause Pate	Indicate post partum contraception method being used  Indicate post partum contraception method being used  Indicate post partum contraception method being used  Infant Death Mother Death  Cause Date Cause Date  Cause Date

### SECTION-II

## Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE (	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (I	PNC)		
		PNC Visit <sup>220</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>221</sup>	Infant <sup>222</sup>	Weight of infant <sup>223</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>220</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
221 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY
222 (A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>223</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	FE MORE VISITS ON 14TH 2		VERY ARE REQUIRED	IFW-4A
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used 225	If died, date and pro Infant Death <sup>226</sup>	bable cause of death  Mother Death  227	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>224 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>225 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>226</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>227</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				11 . 2 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman228	Name of Pregnant Woman	Address	Name of Husband229	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 No. of weeks	14 Registered	15	16 EDD <sup>(1)</sup>	17 Blood	18 Past H/O		19 Past Obstetric	es History		20 Indicate	21 VDRL (RPR)
registration	nregnancy	Weight of PW (KG) at the time of registration		Blood Group of PW [Done (Result)/ Not Done]			Details of last two Pregnancy	Complications	Outcome of Pregnancy <sup>(4)</sup>	expected place and name of facility for delivery <sup>(5)</sup>	test done (date) + VE/VE / Not done
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				
							Last Preg				
							Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## SECTION-M

# Tracking of Pregnant Women

PW - :

				Ante N	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	0	31	3	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)		Wt. of PW (Kg)	BP m Systolic	m Hg Diastolic	Hb (gm%)
							No. of weeks of pregnancy	abortion indicate facility (Govt./Pvt.)				
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

INDUCED
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#### Ante Natal Care (ANC) Details

	1			3				
34			35		36			37
_	(Done/Not Done)  Albumin Sugar (3)		Blood Sugar Test (Done/Not Done)  If done Fasting Post Prandial		TT Dose (Date) Ist 2nd/ Booster		No. Folio Ta (with wee ks	bs**
								of gnand give





37	38	39		40	41	42			
. of lic Acid labs** of thin 12 lee (4)/ Nil	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal	doman exami Foetal presentation /Position		high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>	Maternal death (No/Yes)	If died, date, place & probable cause (8)
of egnanc given					Beaucoal/				
231									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 231 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

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PW - 3







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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>232</sup>	Who Conducted Delivery <sup>233</sup>	Type of Deliver <sup>234</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	rth (1/2) or Still Discharge (If Inst pirth (1/2)	
								(DD/MM/YYYY)	Time (HH:MM)

<sup>232</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>233</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>234</sup> NORMAL / CAESAREAN / ASSISTED

<sup>235 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/ Preterm	If preterm delivery ( >24 weeks & < 34 weeks)		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>237</sup> (G	ven/Not G	
Sr. No. of the	riotom	inj. corticosteriods	infant (M/F)	immediately at birth	ioi iaitiici	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>238</sup>
baby		given to mother (Yes/No/Don't Know)		(Yes/No)	management (Yes/No/NA)	birth <sup>236</sup>		(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>236 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 237 AT THE TIME OF BIRTH 238 INJ. VITABBLE INTERMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72
Sr. N	o. Name of Mother			Post Natal C	Care (PNC)		
		PNC Visit after Delivery <sup>239</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger		
		Donvoly		ouror/vui	Mother <sup>240</sup>	Infant <sup>241</sup>	Weight of infant <sup>242</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>239</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>240 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 241 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

<sup>242</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used	If died, o		bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

### Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE (	HBNC) THREE MORE VISIT	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	QUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (I	PNC)		
		PNC Visit <sup>243</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>244</sup>	Infant <sup>245</sup>	Weight of infant <sup>246</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>243</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
244 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>245 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>246</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

	UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED										
88		89	90	91	92	93					
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>248</sup>	If died, date and pro Infant Death <sup>249</sup>	bable cause of death  Mother Death <sup>250</sup>	Place of death (Home/Hospital/ In Transit)	Remarks (If any)					
Mother	Infant										

<sup>247 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>248 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>249</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>250</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman251	Name of Pregnant Woman	Address	Name of Husband252	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







												_
13	14	15	16	17	18		19			20	21	
No. of weeks of pregnancy at the time of	Registered	Weight of	EDD <sup>(1)</sup>		Past H/O Past Obstetrics History			Indicate expected	VDRL (RPR) test done			
registration	nregnancy	PW (KG) at the time of registration		Group of PW [Done (Result)/ Not Done]			Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done	
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### SECTION-M

## Tracking of Pregnant Women

PW - :

				Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit (1)	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic No	on (if any) <sup>(2)</sup>		Wt. of BP mm Hg Systolic Diast		BP mm Hg	
				ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Oysione	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

25!

#### Ante Natal Care (ANC) Details

			3			d
;	36		35	3	4	3
No. Folio	Dose (ate)		ugar Test ot Done)	Blood S (Done/No		(Done/N
/saciale	2nd/ Booster	Ist	If done Post	lf done Fasting	Sugar <sup>(3)</sup> (P/A)	Albumin (P/A)





4		A THE STATE OF THE													
3	4	3	35		36	37	38			39		40	41	4	<b>42</b>
		Blood S (Done/No	ugar Test		Dose Date)	No. of Folic Acid		Fundal	undal/Ab Foetal	doman exami Foetal	nation Foetal	Any symptom of	Date, type & name of	death	If died, date, place & probable
Albumin (P/A)	Sugar (3)	If done Fasting	If done Post Prandial	lst	2nd/ Booster	ks (4)/ Nil	given (after 12 weeks) <sup>(5)</sup>	Height/		presentation /Position	movements (Normal/Increa sed/	nigh risk"	referral facility <sup>(7)</sup>	(No/Yes)	(8) cause
						of									
						pregnanc v) given									
						y) given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF

IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 254 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

48

PW - 3







43

45

46

47

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Sr. No.		Delivery Outcome									
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>255</sup>	Who Conducted Delivery <sup>256</sup>	Type of Deliver <sup>257</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)		Time of titutional Delivery) Time (HH:MM)		

<sup>255</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>256</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>257</sup> NORMAL / CAESAREAN / ASSISTED

<sup>258 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/ Preterm	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>260</sup> (G	ven/Not G	
Sr. No. of the	rieteilli	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately at birth	101 Turtifici	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>261</sup>
baby		given to mother (Yes/No/Don't Know)	` '	(Yes/No)	management (Yes/No/NA)	birth <sup>259</sup>	3,	(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>259 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 260 AT THE TIME OF BIRTH 261 INJ. VITABBLE INTERMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72	
Sr. No	. Name of Mother			Post Natal C	Care (PNC)			
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to		Indicate danger Sign(s) (If any)		
		Delivery <sup>262</sup>		mother/Nil	Mother <sup>263</sup>	Infant <sup>264</sup>	Weight of infant <sup>265</sup> (Kg)	
		1st Day						
		3rd Day						
		7th Day						
		42 nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						
		1st Day						
		3rd Day						
		7th Day						
		42nd Day						

<sup>262</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>263 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 264 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

<sup>64 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREAS MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>265</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used		date and pro	bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)	

### SECTION-II

### Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	QUIRED			
82	83	84	85	86		87			
Sr. No.	Name of Mother		Post Natal Care (PNC)						
		PNC Visit <sup>266</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger				
				to mother/Nil	Mother <sup>267</sup>	Infant <sup>268</sup>	Weight of infant <sup>269</sup>		
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							

<sup>266</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
267 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>268 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>269</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH, 2		VERY ARE REQUIRED	PW - 4 A
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>271</sup>	If died, date and pro Infant Death <sup>272</sup>	bable cause of death  Mother Death <sup>273</sup>	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>270 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>271 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>272</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>273</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				11 . 2 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman274	Name of Pregnant Woman	Address	Name of Husband275	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







												_
13	14	15	16	17	18		19			20	21	
No. of weeks	Registered	Weight of			Past H/O		Past Obstetrics History				VDRL (RPR) test done	
registration	pregnancy	PW (KG) at the time of		(Result)/		Total No. of				place and	(date) + VE/VE / Not done	(
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
(	13 No. of weeks of pregnancy at the time of registration	No. of weeks of pregnancy within 12 weeks of registration	No. of weeks of pregnancy within tegistration to the time of pregnancy weeks of pregnancy pregnancy the time of pregnancy the time of tegistration to the time of the	13  14  15  16  No. of weeks of pregnancy within weeks registration  12  Weight of PW (KG) at the time of pregnancy of pregnancy registration	13  14  15  16  17  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy	13  14  15  16  17  18  No. of weeks of pregnancy within at the time of registration  12  Weight of PW (KG) at the time of pregnancy of	13  14  15  16  17  18  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy  Weight of PW (KG) at the time of pregnancy  Weight of PW (KG) at the time of pregnancy  Total No. of Pregnancy	No. of weeks of pregnancy at the time of registration registration (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of registration (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of Past H/O (Illness(2))  Total No. of Past Obstetric (Yes/No)  Last Preg  Last to Last Preg  Last to Last Preg  Last to Last Preg	No. of weeks of pregnancy (Yes/No)  No. of weeks pegistred within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of Weight of PW (KG) at the time of registration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of No. of Past H/O Past Obstetrics History  Total No. of Details of last two Complications (3)  Last Preg  Last to Last Preg	No. of weeks of pregnancy within registration of registration of pregnancy (Yes/No)  Registered within 12 (Weight of pregnancy (Yes/No)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Yes/No)  Registration of pregnancy (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Result)/ (Result)/ (Result)/ (Not Done)  Registration of pregnancy (Result)/ (	No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of pregnancy of the time of pregnancy of the time of pregnancy (Not Done)  No. of weeks of pregnancy of pregnancy of pregnancy of the time of pregnancy of pregnancy of pregnancy (Not Done)  No. of weeks of pregnancy of pr	No. of weeks of pregnancy registration of the time of pregnancy (Yes/No) of the time of th

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HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### SECTION-M

# Tracking of Pregnant Women

PW - :

				Ante N	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	3	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of  weeks of  pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	Wt. of PW (Kg)	BP m Systolic	m Hg Diastolic	Hb (gm%)
		1st visit					programoy	(Octobrical)				
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

26!

#### Ante Natal Care (ANC) Details

dd				•		
3	4	3	35		36	37
(Done/N	ot Done)	Blood Si (Done/No	ugar Test ot Done)		Dose Date)	No. o Folic Acid Tabs**
Albumin (P/A)	•	If done Fasting	Post	Ist	2nd/ Booster	(within 12 wee
			Prandial			ks 17 N
						pregnand
						y) givei



277 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT



37	38			39		40	41	4	12
of	No of IFA	F	undal/Ab	doman exami	nation	Any	Date, type &		If died, date, place &
c Acid abs** hin 12	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	roto	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable cause (8)
of gnanc									
given									
"									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL / PRIVATE HOSPITAL / OTHER (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

48

PW - 3







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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>278</sup>	Who Conducted Delivery <sup>279</sup>	Type of Deliver <sup>280</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)	Discharge (If Inst	Time of titutional Delivery)
				-				(DD/MM/YYYY)	Time (HH:MM)

<sup>278</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>279</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>280</sup> NORMAL / CAESAREAN / ASSISTED

<sup>281 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>283</sup> (G	ven/Not G	iven)
<b>6</b> 11 44	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	HEP B	VIT K <sup>284</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)		at birth (Yes/No)	management (Yes/No/NA)	birth <sup>282</sup>	birtir (Rg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>282 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 283 AT THE TIME OF BIRTH 284 INJ. VIATABRIS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

6	66	67	68	69	70	71	72
Sr.	Name of Mother			Post Natal C	Care (PNC)		
		PNC Visit after Delivery <sup>285</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>286</sup>	Sign(s) (If any)	
					Motrici	mane	Weight of infant <sup>288</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>285</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>286 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>287 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>288</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81	
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used			bable cause of Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)	
Mother	Infant		Cause	Date	Cause	Date	Transit)		

### **SECTION-II**

### Tracking of Pregnant Women

UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED											
82	83	84	85	86	87						
Sr. No.											
	Name of Mother	PNC Visit <sup>289</sup> After Delivery	Date of PNC Visit	Post Natal Care (F No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)						
					Mother <sup>290</sup>	Infant <sup>291</sup>	Weight of infant <sup>292</sup>				
		14th Day									
		21st Day									
		28th Day									
		14th Day									
		21st Day									
		28th Day									
		14th Day									
		21st Day									
		28th Day									
		14th Day									
		21st Day									
		28th Day									

<sup>289</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
290 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>291 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>292</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Traordi	ig of Fregulatic Wolf	1011		PVV - 4 A					
UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED											
88		89	90	91	92	93					
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>294</sup>	If died, date and probable cause of death Infant Death <sup>295</sup> Mother Death <sup>296</sup>		Place of death (Home/Hospital/ In Transit)	Remarks (If any)					
Mother	Infant										

<sup>293 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>294 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>295</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>296</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				11 1 7 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman297	Name of Pregnant Woman	Address	Name of Husband298	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18		19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>		Past Obstetrics History  otal No. of Pregnancy Complications Outcome of Pregnancy (3) Pregnancy		Indicate expected	VDRL (RPR) test done	
registration (Yes/No)	the time	me of	PW [Done (Result)/						place and	(date) + VE/VE / Not done
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-M**

## Tracking of Pregnant Women

				Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic	on (if any) <sup>(2)</sup>		Wt. of PW	BP m	m Hg	Hb (gm%)
			ANO	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

3	4		35		36		37
Urine (Done/N	Test ot Done)	Blood S (Done/No	ugar Test ot Done)	тт	Dose Date) 2nd/ Booster	Ta (with wee ks	o Acid bs** nin 12 (4)/ Ni
							gnanc giver



300 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT



37	38			39		40	41	4	<b>1</b> 2
of ic Acid abs** hin 12	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the	Foetal	doman exami Foetal presentation /Position	ration Foetal movements (Normal/Increa	high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>		If died, date, place & probable cause (8)
of gnanc		uterus			Dearcoad				
given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

48

PW - 3







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Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>301</sup>	Who Conducted Delivery <sup>302</sup>	Type of Deliver <sup>303</sup>	Complication	Out come of delivery: Live birth (1/2) or Still birth (1/2)		Time of titutional Delivery)
				,			` ,	(DD/MM/YYYY)	Time (HH:MM)

<sup>301</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>302</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>303</sup> NORMAL / CAESAREAN / ASSISTED

<sup>304 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/ Preterm	If preterm delivery ( >24 weeks & < 34 weeks)		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>306</sup> (G	ven/Not G	
Sr. No. of the	rictoriii	inj. corticosteriods	Sex of infant (M/F)	IIIIIIIeuialeiy	higher facility for further	defect seen at birth <sup>305</sup>	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>307</sup>
baby		given to mother (Yes/No/Don't Know)		(Yes/No)	management (Yes/No/NA)	birth		(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>305 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 306 AT THE TIME OF BIRTH 307 INJ. VITABBLE INTERMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

6	66	67	68	69	70	71	72
Sr. I	o. Name of Mother			Post Natal C	Care (PNC)		
		PNC Visit after Delivery <sup>308</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger		
		Denvery		mound//til	Mother <sup>309</sup>	Infant <sup>310</sup>	Weight of infant <sup>311</sup> (Kg)
		1st Day					
		3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>308</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 309 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>310 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>311</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used	If died, date and prob		bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

## Tracking of Pregnant Women

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE R	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (I	PNC)		
		PNC Visit <sup>312</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange	r sign (s) (If any)	
				to mother/Nil	Mother <sup>313</sup>	Infant <sup>314</sup>	Weight of infant <sup>315</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day 14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>312</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
313 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>314 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>315</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

Tracking of Fregulatit Women											
	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	E MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELI	VERY ARE REQUIRED						
88		89	90	91	92	93					
If danger sign (s) present for mother or infant, indicate place & name of referral facility <sup>316</sup>		Indicate post partum contraception method being used <sup>317</sup>	If died, date and pro Infant Death <sup>318</sup>	bable cause of death Mother Death <sup>319</sup>	Place of death (Home/Hospital/ In Transit)	Remarks (If any)					
Mother	Infant										

<sup>316 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>317 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>318</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>319</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				// 1 7 /							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman320	Name of Pregnant Woman	Address	Name of Husband321	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







13	14	15	16	17	18	19			20	21	
No. of weeks of pregnancy at the time of	Registered	Weight of	EDD <sup>(1)</sup>		Past H/O Illness <sup>(2)</sup>	Past Obstetric	s History		Indicate expected	VDRL (RPR) test done	S
registration	nregnancy	PW (KG) at the time of registration		Blood Group of PW [Done (Result)/ Not Done]		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done	t (d
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					
						Last Preg					
						Last to Last Preg					

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

### **SECTION-M**

## Tracking of Pregnant Women

				Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic	tion (if any) <sup>(2)</sup>		Wt. of PW	BP m	m Hg	Hb (gm%)
			ANO	ANC done	pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

\471							
da			3	9			
3	4	3	35		36	,	37
		Blood Si (Done/No	ugar Test ot Done)		Dose Date)		Aci
Albumin (P/A)	J	If done Fasting	If done Post Prandial	Ist	2nd/ Booster	(with wee ks	bs** nin 1 <sup>(4)</sup> / N
			Fianulai				of
						y) 322 323	gnand give
						322	





37	38			39		40	41	4	12
. of	No of IFA	F		doman exami		Any	Date, type &		If died, date, place &
lic Acid Tabs** thin 12 te (4)/ Nil	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	roto	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	symptom of high risk <sup>(6)</sup> please indicate	name of referral facility <sup>(7)</sup>	(No/Yes)	probable (8) cause
of									
egnanc given									
				<u> </u>					

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY ) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY) 323 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

PW - 3







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			l						
Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>324</sup>	Who Conducted	Type of Deliver <sup>326</sup>	Complication During	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery <sup>325</sup>		Delivery <sup>327</sup>	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)
								•	

<sup>324</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>325</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>326</sup> NORMAL / CAESAREAN / ASSISTED

<sup>327 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

## **SECTION-II**

**Tracking of Pregnant Women** 

					<u> </u>	diff Wolffer						W - J
					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>329</sup>	ven/Not G	iven)
On No. of the	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	miniculatory	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	HEP B	VIT K <sup>330</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)		at birth (Yes/No)	management (Yes/No/NA)	birth <sup>328</sup>	Dirtii (itg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>328 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 329 AT THE TIME OF BIRTH 330 INJ. VITABBLE INTERMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72			
Sr. No.	Name of Mother			Post Natal Care (PNC)						
		PNC Visit after Delivery <sup>331</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>332</sup>	Sign(s) (If any)	Weight of infant <sup>334</sup> (Kg)			
		1st Day					Weight of finant (Kg)			
		3rd Day								
		7th Day								
		42 nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								

<sup>331</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>332 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 333 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

334 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used		date and pro	bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)	

### SECTION-II

## Tracking of Pregnant Women

	U	NDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH D	AY OF DELIVERY ARE RE	QUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (F	PNC)		
		PNC Visit <sup>335</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>336</sup>	Infant <sup>337</sup>	Weight of infant <sup>338</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>335</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
336 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>337 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>338</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Haokii	ig of Fregulatic Wolf	1011		PVV - 4 A
	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELI	VERY ARE REQUIRED	
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>340</sup>	If died, date and pro Infant Death <sup>341</sup>	If died, date and probable cause of death Infant Death <sup>341</sup> Mother Death <sup>342</sup>		Remarks (If any)
Mother	Infant					



<sup>339 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>340 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>341</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>342</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				11 1 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman343	Name of Pregnant Woman	Address	Name of Husband344	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18	19			20	21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>	Past Obstetric	s History		Indicate expected	VDRL (RPR) test done
registration (Yes/No)	the time	me of	PW [Done (Result)/		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## SECTION-M

# Tracking of Pregnant Women

PW - :

				Ante N	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of  weeks of pregnancy	abortion indicate facility	Wt. of PW (Kg)	BP mi Systolic	m Hg Diastolic	Hb (gm%)
		1st visit 2nd visit										
		3rd visit 4th visit										
		1st visit 2nd visit										
		3rd visit 4th visit										
		1st visit										
		2nd visit 3rd visit										
		4th visit 1st visit										
		2nd visit 3rd visit										
		4th visit										l

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

1NDUCED
29!

#### Ante Natal Care (ANC) Details

de			3				
	34	3	35		36		37
(Done/I	e Test lot Done)	(Done/No		([	Dose Date)		o Acio bs**
Albumii (P/A)	Sugar <sup>(3)</sup> (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster		nin 12
							of
						y) 345 346	gnanc giver





37	38			39		40	41	4	42
of ic Acid abs** hin 12	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal	doman exami	ration Foetal movements (Normal/Increa	Any symptom of high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>		If died, date, place & probable cause (8)
of gnanc		uterus			Doomood				
given 46									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY.

<sup>(4)</sup> TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY)

<sup>(5)</sup> TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF

IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME

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PW - 3







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Sr. No.	No. Delivery Outcome									
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>347</sup>	Who Conducted	Type of Deliver <sup>349</sup>	Complication During	Out come of delivery: Live birth (1/2) or Still			
		Delivery		Delivery <sup>348</sup>		Delivery <sup>350</sup>	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)	

<sup>347</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>348</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>349</sup> NORMAL / CAESAREAN / ASSISTED

<sup>350 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

	Infant Details											
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding started within one hour of birth (Yes/No)	Birth	Dose <sup>352</sup> (G	ven/Not G iven)	
Sr. No. of the baby	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	immediately	higher facility for further management (Yes/No/NA)	defect seen at birth <sup>351</sup>	Weight at birth (Kg)		OPV	BCG	HEP B	VIT K <sup>353</sup>
									Date	Date	Date	Date
BABY 1					,							
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>351 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 352 AT THE TIME OF BIRTH 353 INJ. VITABBUS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE-0.5 mg)

NA - NOT APPLICABLE

(	65	66	67	68	69	70	71	72			
Sr.	No.	Name of Mother			Post Natal Care (PNC)						
			PNC Visit after Delivery <sup>354</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>355</sup>	Sign(s) (If any) Infant <sup>356</sup>	257			
			4 at Davi					Weight of infant <sup>357</sup> (Kg)			
			1st Day 3rd Day								
			7th Day								
			42 nd Day								
			1st Day								
			3rd Day								
			7th Day								
			42nd Day								
			1st Day								
			3rd Day								
			7th Day								
			42nd Day								
			1st Day								
			3rd Day								
			7th Day								
			42nd Day								

<sup>354</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 355 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>356 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>357</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used		date and pro	bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

	U	NDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	EQUIRED			
82	83	84	85	86		87			
Sr. No.	Name of Mother			Post Natal Care (	e (PNC)				
		PNC Visit <sup>358</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)			
				to mother/Nil	Mother <sup>359</sup>	Infant <sup>360</sup>	Weight of infant <sup>361</sup>		
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							
		14th Day							
		21st Day							
		28th Day							

<sup>358</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
359 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>360 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>361</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED										
88		89	90	91	92	93				
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used 363	If died, date and probable cause of death Infant Death <sup>364</sup> Mother Death <sup>365</sup> (Ho		Place of death (Home/Hospital/ In Transit)	Remarks (If any)				
Mother	Infant									

<sup>362 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>363 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>364</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>365</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













				// 1 7 /							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman366	Name of Pregnant Woman	Address	Name of Husband367	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

#### **General Information**







13 14	15	16	17	18	19				21
No. of weeks of pregnancy at the time of	ed Weight	EDD <sup>(1)</sup>	Blood Group of	Past H/O Illness <sup>(2)</sup>	Past Obstetrics History		Indicate expected	VDRL (RPR) test done	
registration (Yes/No)	the time	me of	PW [Done (Result)/		otal No. of Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				
					Last Preg				
					Last to Last Preg				

(1) FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

(2) (A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## **SECTION-M**

## Tracking of Pregnant Women

PW - 2

1	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	30	)	31	32		33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortic No	tion (if any) <sup>(2)</sup>		Wt. of BP mm H		n Hg	Hb (gm%)
				ANC done	pregnancy		If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Systolic	Diastolic	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

INDUCED
30!

#### Ante Natal Care (ANC) Details

34	35	36	37
Urine Test (Done/Not Done Albumin (P/A) Sugar (P/A)	(3) If done If doi	e) (Date) ne Ist 2nd/ Booster	No. of Folic Aci Tabs** (within 1 wee ks
			of pregnand y) give



369 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT



37	38			39		40	41	4	12
. of lic Acid labs** of thin 12	No of IFA Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal	doman examing Foetal presentation /Position		high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>	Maternal death (No/Yes)	If died, date, place & probable cause (8)
of egnanc given					Province of I				
369									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY ) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

PW - 3







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Sr. No.		Delivery Outcome							
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>370</sup>	Who Conducted	Type of Deliver <sup>372</sup>	During	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery <sup>371</sup>		Delivery <sup>373</sup>	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)

<sup>370</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>371</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>372</sup> NORMAL / CAESAREAN / ASSISTED

<sup>373 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Dose <sup>375</sup> Birth		ven/Not G	iven)
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	НЕР В	VIT K <sup>376</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illiant (Wi/1)	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>374</sup>	birtir (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1		(100/10/2011 CTUITOU)		(100,110)	(10011101111111			(100,110)			Duit	
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>374 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 375 AT THE TIME OF BIRTH 376 INJ. VITABBUS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72				
Sr. N	o. Name of Mother			Post Natal C	Post Natal Care (PNC)						
		PNC Visit after Delivery <sup>377</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)  Mother <sup>378</sup> Infant <sup>379</sup>						
							Weight of infant <sup>380</sup> (Kg)				
		1st Day									
		3rd Day									
		7th Day									
		42 nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									

<sup>377</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 378 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>379 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>380</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for mother or infant, indicated and place & name of referral facility		Indicate post partum contraception method being used	partum contraception		bable cause Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)	

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH D	AY OF DELIVERY ARE RI	EQUIRED							
82	83	84	85	86		87							
Sr. No.	Name of Mother	Post Natal Care (PNC)											
		PNC Visit <sup>381</sup> After Delivery	Date of PNC Visit		Indicate danger sign (s) (If any)								
				No. of IFA Tabs given- to mother/Nil	Mother <sup>382</sup>	Infant <sup>383</sup>	Weight of infant <sup>384</sup>						
		14th Day											
		21st Day											
		28th Day											
		14th Day											
		21st Day											
		28th Day 14th Day											
		14til Day											
		21st Day											
		28th Day											
		14th Day											
		21st Day											
		28th Day											

<sup>381</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
382 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>383 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>384</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Traordi	ig of Fregulatic Wolf			PVV - 4 A
	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	E MORE VISITS ON 14TH, 2	21ST , & 28TH DAY OF DELI	VERY ARE REQUIRED	
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used 386	If died, date and pro Infant Death <sup>387</sup>	bable cause of death  Mother Death  **Both Common C	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>385 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>386 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>387</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>388</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman389	Name of Pregnant Woman	Address	Name of Husband390	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration







H. M.										
13	14	15	16	17	18	19			20	21
No. of weeks of pregnancy at the time of	Registered	Weight of	EDD <sup>(1)</sup>	Blood	Past H/O Illness <sup>(2)</sup>	Past Obstetrics History		Indicate expected	VDRL (RPR) test done	
registration	nregnancy	PW (KG) at the time of registration		PW [Done (Result)/ Not Done]		Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				
						Last Preg				
						Last to Last Preg				

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

				Ante Na	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	Wt. of PW (Kg)	BP mi	m Hg Diastolic	Hb (gm%)
		1st visit 2nd visit 3rd visit										
		4th visit 1st visit										
		2nd visit  3rd visit  4th visit										
		1st visit 2nd visit										
		3rd visit 4th visit										
		1st visit 2nd visit 3rd visit										
		1st visit 2nd visit										

<sup>(1)</sup> IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

					37
(Done/N	Test ot Done)	-	Dose Date) 2nd/ Booster	No. Folio	of Acid bs** nin 12
				preg	of gnanc given



392 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT



37	38			39		40	41	4	12
of	No of IFA	F	undal/Ab	doman examiı	nation	Any	Date, type &	Maternal death	If died, date, place &
c Acid bs** nin 12	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable (8) cause
of gnanc given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

PW - 3







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Sr. No.			'		Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>393</sup>	Who Conducted	Type of Deliver <sup>395</sup>	Complication	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery <sup>394</sup>		Delivery	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)

<sup>393</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>394</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>395</sup> NORMAL / CAESAREAN / ASSISTED

<sup>396 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/ Preterm	If preterm delivery ( >24 weeks & < 34 weeks)		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>398</sup> (G	ven/Not G	
Sr. No. of the	rieteilli	inj. corticosteriods	Sex of infant (M/F)	IIIIIIIeuiateiy	higher facility for further	defect seen at	Weight at birth (Kg)	started within one hour of birth	OPV	BCG	HEP B	VIT K <sup>399</sup>
baby		given to mother (Yes/No/Don't Know)	, i	(Yes/No)	management (Yes/No/NA)	birth <sup>397</sup>	. 0,	(Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>397 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 398 AT THE TIME OF BIRTH
399 INJ. VITABRIS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72
Sr. No.	Name of Mother			Post Natal C	Care (PNC)		
		PNC Visit after Delivery <sup>400</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>401</sup>	Sign(s) (If any) Infant <sup>402</sup>	403 415
		4 at Day					Weight of infant <sup>403</sup> (Kg)
		1st Day 3rd Day					
		7th Day					
		42 nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					
		1st Day					
		3rd Day					
		7th Day					
		42nd Day					

<sup>400</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>401 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 402 (A) JAUNDICE, (B) DIARRHOFA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULT Y IN FEEDING (UNABLE TO SUCK (DECREASE

<sup>402 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>403</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died, date and probable cause of de Infant Death Mother Death			Place of death (Home/Hospital/ In	Remarks (If any)	
Mother	Infant		Cause	Date	Cause	Date	Transit)	

	U	NDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE RE	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (	PNC)		
		PNC Visit <sup>404</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate danger	sign (s) (If any)	
				to mother/Nil	Mother <sup>405</sup>	Infant <sup>406</sup>	Weight of infant <sup>407</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>404</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
405 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>406 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>407</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

	UNDER HOME BASED NEV	WBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH.		IVERY ARE REQUIRED	PW - 4 A
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>409</sup>	partum contraception Infant Death 410 Mother Death 411		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>408 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>409 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>410</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>411</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.













	IGNU			1 . 3							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman412	Name of Pregnant Woman	Address	Name of Husband413	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

<sup>412</sup>SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I 413IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE







13 14 15 16			16	17	18		19	20	21			
No. of weeks Re	Registered within 12 weeks of pregnancy (Yes/No)	Weight of	e of	Blood Group of PW [Done (Result)/ Not Done]	•		Past Obstetric	Indicate expected	VDRL (RPR) test done			
registration pre		PW (KG) at					Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done	
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## SECTION-M

# Tracking of Pregnant Women

PW - 2

				Ante N	atal Care (AN	C) Deta	ils					
23	24	25	26	27	28	29	30	0	31	32	2	33
Sr. No.	Pregnant Woman  ANC Visit (1)  ANC Place/Site of ANC done pregu		No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of  weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	Wt. of PW (Kg)	BP mi	m Hg Diastolic	Hb (gm%)		
		1st visit 2nd visit										
		3rd visit										
		4th visit										
		2nd visit										
		3rd visit										
		4th visit 1st visit										
		2nd visit										
		3rd visit										
		4th visit 1st visit										-
		2nd visit										
		3rd visit 4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETW WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC. IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34

INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

#### Ante Natal Care (ANC) Details

d							
3	4	3	35		36		37
Urine (Done/N	e Test ot Done) Sugar <sup>(3)</sup>	Blood So (Done/No If done	ugar Test ot Done)	TT (E	Dose Date) 2nd/ Booster	No. Folic	of Acid bs** in 12
(174)	(P/A)	Fasting	Post Prandial		Dooster	wee ks	
			Tarada			(	of
						-	nanc given





37	38			39		40	41	4	12
of	No of IFA	F	undal/Ab	doman examiı	nation	Any	Date, type &		If died, date, place &
c Acid bs** nin 12	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable (8) cause
of gnanc given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G) TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME

PW - 3







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Cu Na					Delivery Order	****			
Sr. No.	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery <sup>416</sup>	Who Conducted Delivery <sup>417</sup>	Type of Deliver <sup>418</sup>		Out come of delivery: Live birth (1/2) or Still birth (1/2)		Time of titutional Delivery)
							, ,	(DD/MM/YYYY)	Time (HH:MM)

<sup>416</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>417</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>418</sup> NORMAL / CAESAREAN / ASSISTED

<sup>419 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>421</sup> (G	ven/Not G	iven)
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at birth (Kg)	started within one	OPV	BCG	НЕР В	VIT K <sup>422</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illiant (iw/i )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>420</sup>	birtir (Ng)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>420 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 421 AT THE TIME OF BIRTH 422 INJ. VITABBLE INTERNATIONAL TO STAND THE FORM OF THE FORM OF

NA - NOT APPLICABLE

6	5	66	67	68	69	70	71	72
Sr.	No.	Name of Mother			Post Natal C	Care (PNC)		
			PNC Visit after Delivery <sup>423</sup>	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger  Mother <sup>424</sup>	Sign(s) (If any) Infant <sup>425</sup>	420
			4 at Davi					Weight of infant <sup>426</sup> (Kg)
			1st Day 3rd Day					
			7th Day					
			42 nd Day					
			1st Day					
			3rd Day					
			7th Day					
			42nd Day					
			1st Day					
			3rd Day					
			7th Day					
			42nd Day					
			1st Day					
			3rd Day					
			7th Day					
			42nd Day					

<sup>423</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)

<sup>424 (</sup>A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY, 425 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED

MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

426 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used		date and pro	bable cause of death  Mother Death		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause	Date	Transit)	

### SECTION-II

## Tracking of Pregnant Women

	l	JNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH D	AY OF DELIVERY ARE RI	EQUIRED	
82	83	84	85	86		87	
Sr. No.	Name of Mother			Post Natal Care (F	PNC)		
		PNC Visit <sup>427</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange	r sign (s) (If any)	
				to mother/Nil	Mother <sup>428</sup>	Infant <sup>429</sup>	Weight of infant <sup>430</sup>
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day 14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

<sup>427</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
428 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>429 (</sup>A) JAUNDICE (B) DIARRHOEA (C) VOMITING (D) FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>430</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

		Hackii	ig of Fregulatic Wolf	IGII		IPVV - 4 A
	UNDER HOME BASED NE	WBORN CARE (HBNC) THRE	EE MORE VISITS ON 14TH,	21ST , & 28TH DAY OF DEL	VERY ARE REQUIRED	
8	8	89	90	91	92	93
If danger sign (s) present for mother or infant, indicate place & name of referral facility <sup>431</sup>		Indicate post partum contraception method being used 432	If died, date and pro Infant Death <sup>433</sup>	If died, date and probable cause of death Infant Death <sup>433</sup> Mother Death <sup>434</sup>		Remarks (If any)
Mother	Infant				(Home/Hospital/ In Transit)	

<sup>431 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>432 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>433</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>434</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.

#### **General Information**













	IGNU			11 . 2 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman435	Name of Pregnant Woman	Address	Name of Husband436	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

#### **General Information**







H. M.												
13	14	15	16	17	18		19		20	21		
No. of weeks of pregnancy at the time of	Registered	Weight of	EDD <sup>(1)</sup>	Blood Past H/O Illness <sup>(2)</sup>		od Past H/O Past Obstetrics		Past Obstetrics History		Indicate expected	VDRL (RPR) test done	
registration	nregnancy	PW (KG) at the time of registration		PW [Done (Result)/ Not Done]			Details of last two Pregnancy		Outcome of Pregnancy <sup>(4)</sup>	place and	(date) + VE/VE / Not done	
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## SECTION-M

# Tracking of Pregnant Women

PW - :

	Ante Natal Care (ANC) Details												
23	24	25	26	27	28	29	30	)	31	32	2	33	
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit <sup>(1)</sup>	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	No	on (if any) <sup>(2)</sup> If Yes, (I/S)  No. of  weeks of pregnancy	abortion indicate facility	Wt. of PW (Kg)	BP mi Systolic	m Hg Diastolic	Hb (gm%)	
		1st visit 2nd visit											
		3rd visit 4th visit											
		1st visit 2nd visit											
		3rd visit 4th visit											
		1st visit											
		2nd visit 3rd visit											
		4th visit 1st visit											
		2nd visit 3rd visit											
		4th visit										l	

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

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#### Ante Natal Care (ANC) Details

d				9			1	
3	34		35		36	37		
(Done/N	Urine Test (Done/Not Done)		ugar Test ot Done)	TT Dose (Date)		No. Folic Ac Tabs**		
Albumin (P/A)	Sugar <sup>(3)</sup> (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster	(with wee ks	in	
						preg	giv	





37	38			39		40	41	4	12
of c Acid	No of IFA Tabs	F	undal/Ab Foetal	doman exami		Any symptom of	Date, type &		If died, date, place &
bs** nin 12	given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the		presentation /Position	movements (Normal/Increa	high risk <sup>(6)</sup>	name of referral facility <sup>(7)</sup>	(No/Yes)	probable cause (8)
of		uterus			Desmond				
gnanc									
given									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY). (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)
TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), (B). AND ALSO INDICATE TYPE OF REFERRAL FACILITY (PHC/ CHC / DIST HOSPITAL/ OTHER (SPECIFY), AND WRITE NAME

PW - 3







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			I						
Sr. No.					<b>Delivery Outco</b>	me			
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>439</sup>	Who Conducted	Type of Deliver <sup>441</sup>	Complication During	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery <sup>440</sup>		Delivery <sup>442</sup>	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)

<sup>439</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>440</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>441</sup> NORMAL / CAESAREAN / ASSISTED

<sup>442 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth G V		ven/Not G	
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	immediately	higher facility for further	defect seen at	Weight at	started within one	OPV	BCG	HEP B	VIT K <sup>445</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illiant (W/I )	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>443</sup>	birth (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>443 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 444 AT THE TIME OF BIRTH
445 INJ. VITABBLE INTERNAL STATEMENT OF THE FORMAN STATEMENT OF

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72			
Sr. No.	Name of Mother			Post Natal Care (PNC)						
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to		Indicate danger Sign(s) (If any)				
		Delivery <sup>446</sup>		mother/Nil	Mother <sup>447</sup>	Infant <sup>448</sup>	Weight of infant <sup>449</sup> (Kg)			
		1st Day								
		3rd Day								
		7th Day								
		42 nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								
		1st Day								
		3rd Day								
		7th Day								
		42nd Day								

 <sup>446</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT)
 447 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,
 448 (A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>449</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81	
If danger sign (s) present for place & name of r		Indicate post partum contraception method being used	If died, o		bable cause of Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)	
Mother	Infant		Cause	Date	Cause	Date	Transit)		

### SECTION-II

## Tracking of Pregnant Women

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH [	DAY OF DELIVERY ARE R	EQUIRED						
82	83	84	85	86		87						
Sr. No.	Name of Mother		Post Natal Care (PNC)									
		PNC Visit <sup>450</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange	r sign (s) (If any)						
				to mother/Nil	Mother <sup>451</sup>	Infant <sup>452</sup>	Weight of infant <sup>453</sup>					
		14th Day										
		21st Day										
		28th Day										
		14th Day										
		21st Day										
		28th Day 14th Day										
		21st Day										
		28th Day										
		14th Day										
		21st Day										
		28th Day										

<sup>450</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
451 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>452 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>453</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4 A

	LINDED HOME DAGED HE		TE MODE VISITE ON 44TH 4		VEDY ARE REQUIRED	IFW-4A
000		WBORN CARE (HBNC) THRE				00
88		89	90	91	92	93
If danger sign (s) present for place & name of re		Indicate post partum contraception method being used <sup>455</sup>	If died, date and pro Infant Death <sup>456</sup>	bable cause of death  Mother Death <sup>457</sup>	Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant					

<sup>454 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>455 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>456</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>457</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.

#### **General Information**













	IGNU			1 . 1							
1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	MCTS ID No of Pregnant Woman458	Name of Pregnant Woman	Address	Name of Husband459	Mobile. No (Self/husband / neighbor/ family) (specify)	Religion	Caste SC/ST/ other	BPL/ APL	Age of PW (DOB)		Date of Registration

#### **General Information**







											_	
13	14	15	16	17	18		19			20	21	
No. of weeks	Registered	Weight of			Past H/O		Past Obstetrics History			Indicate expected	VDRL (RPR) test done	
registration	pregnancy	PW (KG) at the time of		(Result)/		Total No. of	Details of last two Pregnancy			place and	(date) + VE/VE / Not done	(
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
							Last Preg					
							Last to Last Preg					
(	13 No. of weeks of pregnancy at the time of registration	No. of weeks of pregnancy within 12 weeks of registration	No. of weeks of pregnancy within tegistration to the time of pregnancy weeks of pregnancy pregnancy the time of pregnancy the time of tegistration to the time of the	13  14  15  16  No. of weeks of pregnancy within weeks registration  12  Weight of PW (KG) at the time of pregnancy of pregnancy registration	13  14  15  16  17  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy	13  14  15  16  17  18  No. of weeks of pregnancy within at the time of registration  12  Weight of PW (KG) at the time of pregnancy of	13  14  15  16  17  18  No. of weeks of pregnancy at the time of registration  12  Weight of PW (KG) at the time of pregnancy  Weight of PW (KG) at the time of pregnancy  Total No. of Pregnancy  Past H/O Blood Group of PW [Done (Result)/ Pregnancy	No. of weeks of pregnancy at the time of registration registration (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of registration (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of Past H/O (Illness(2))  Total No. of Past Obstetric (Yes/No)  Last Preg  Last to Last Preg  Last to Last Preg  Last to Last Preg	No. of weeks of pregnancy (Yes/No)  No. of weeks pegistred within weeks pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of weeks pregnancy within weeks pregnancy (Yes/No)  No. of weeks pegistration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of Weight of PW (KG) at the time of registration  No. of PW (KG) at the time of pregnancy (Yes/No)  No. of No. of Past H/O Past Obstetrics History  Total No. of Details of last two Complications (3)  Last Preg  Last to Last Preg	No. of weeks of pregnancy within registration of registration of pregnancy (Yes/No)  No. of weeks of pregnancy (Yes/No)  Registered within 12 (Weight of pregnancy (Yes/No)  No. of weeks of pregnancy (No. of pregnancy (Yes/No)  No. of weeks of pregnancy (No. of pregnancy (Yes/No)  No. of weeks of pregnancy (No. of pregnancy (No. of pregnancy)  No. of weeks of pregnancy (No. of pregnancy)  No. of pregnancy (No.	No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy at the time of pregnancy (Yes/No)  No. of weeks of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of the time of pregnancy of the time of pregnancy (Yes/No)  No. of weeks of pregnancy of pregnancy of pregnancy of the time of pregnancy of the time of pregnancy (Not Done)  No. of weeks of pregnancy of pregnancy of pregnancy of the time of pregnancy of pregnancy of pregnancy (Not Done)  No. of weeks of pregnancy of pr	No. of weeks of pregnancy registration of the time of pregnancy (Yes/No) of the time of

22

HIV screening test done (date) test - VE / not done<sup>(6)</sup>

<sup>(1)</sup> FOR CALCULATING EXPECTED DATE OF DELIVERY - REFER READY RECKONER TABLE (ANNEXURE-1 OF THIS REGISTER),

<sup>(2) (</sup>A) TB, (B) DIABETES, (C) HYPERTENSION, (D) HEART DISEASE, (E) EPILEPTIC (CONVULSIONS), (F) STI / RTI, (G) HIV+VE, (H) HEPATITIS B, (I) ASTHMA, (J) ANY OTHER (SPECIFY) (K) NONE

(3) ANY COMPLICATION DURING PAST PREGNANCY: (A) CONVULSIONS, (B) APH, (C) PREGNANCY INDUCED HYPERTENSION (PIH), (D) REPEATED ABORTION, (E) STILLBIRTH, (F) CONGENITAL ANOMALY, (G) CAESAREAN -SECTION, (H)

## **SECTION-M**

## Tracking of Pregnant Women

PW - 2

	Ante Natal Care (ANC) Details											
23	24	25	26	27	28	29	30	)	31	32	2	33
Sr. No.	Name of Pregnant Woman	Serial No. of ANC Visit (1)	Date of ANC	Facility/ Place/Site of	No. of weeks of	Abortio	Abortion (if any) <sup>(2)</sup>		Wt. of BP mm Hg	m Hg Diastolic	Hb (gm%)	
				ANC done	pregnancy	110	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)	(Kg)	Gystolic	Diastono	
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										
		1st visit										
		2nd visit										
		3rd visit										
		4th visit										

(1) IDEALLY ANC VISITS SHOULD BE -1ST VISIT - WITHIN 12 WEEKS OF PREGNANCY; 2ND VISIT - WITHIN 14 TO 26 WEEKS OF PREGNANCY; 3RD VISIT - WITHIN 28-34 WEEKS OF PREGNANCY, (PREFERABLY TO BE DONE BY THE MEDICAL OFFICER) 4TH VISIT BETWEEN 34 WEEKS AND FULL TERM. IF MOTHER COMES FIRST TIME, ANYTIME DURING HER PREGNANCY, SHE SHOULD BE ENTERED IN FIRST VISIT COLUMN. GIVE HER ALL THE SERVICES DUE TO HER AS PER THE PERIOD OF PREGNANCY INCLUDING SERVICES OF FIRST ANC.

<sup>(2)
/</sup>SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

INDUCED
34!

#### Ante Natal Care (ANC) Details

d			3			37
Urine (Done/N	Urine Test (Done/Not Done)  Albumin Sugar (3) (P/A) (P/A)		ugar Test ot Done) If done Post Prandial	Dose Date)  2nd/ Booster	No. Folio	o Acid bs** nin 12
						of gnanc giver



461 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT



37	38			39		40	41	4	42
of	No of IFA	F	undal/Ab	doman exami	nation	Any		Maternal	If died, date,
	Tabs given (after 12 weeks) <sup>(5)</sup>	Fundal Height/ Size of the uterus	rato	Foetal presentation /Position	Foetal movements (Normal/Increa sed/	high risk <sup>(6)</sup>	Date, type & name of referral facility <sup>(7)</sup>	(No/Yes)	place & probable (8) cause
of egnanc									
given									
<b>6</b> 1									

<sup>(3)</sup> IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 | jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL'. (6) (A) HIGH BP (SYSTOLIC > 140 AND OR DIASTOLIC > 90 mmHg) (B) CONVULSIONS (C) VAGINAL BLEEDING (D) FOUL SMELLING DISCHARGE (E) SEVERE ANAEMIA (Hb LEVEL < 7 GMS%) (F) DIABETES (G)

TWINS (H) ANY OTHER SPECIFY (I) NONE. (7) (A). INDICATE REASON FOR REFERRAL (HIGH RISK / OTHER SERVICES (SPECIFY), AND WRITE NAME OF FACILITY (E.G. PHC- RAMGARD, CHC -SHYAMNAGAR ETC.) (8) PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE, HIGH FEVER, ABORTION, OTHER (SPECIFY)

PW - 3







43

44

45

46

47

48

49

50

Sr. No.					Delivery Outco	me			
	Name of PW	Date & Time (HH:MM) of	Place of Delivery <sup>462</sup>	Who Conducted	Type of Deliver <sup>464</sup>	During	Out come of delivery: Live birth (1/2) or Still		Time of titutional Delivery)
		Delivery		Delivery <sup>463</sup>		Delivery <sup>465</sup>	birth (1/2)	(DD/MM/YYYY)	Time (HH:MM)

<sup>462</sup> DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME

<sup>463</sup> ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)

<sup>464</sup> NORMAL / CAESAREAN / ASSISTED

<sup>465 (</sup>A) PPH, (B) RETAINED PLACENTA, (C) OBSTRUCTED LABOUR, (D) PROLAPSED CORD, (E) TWINS PREGNANCY, (F) CONVULSIONS, (G) DEATH (IF DIED, INDICATE PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HIGH FEVER, HAEMORRHAGE, OBSTRUCTED LABOUR, PROLONGED LABOUR, OTHER (SPECIFY)

PW - 3

					Infant Deta	ails						
	Full term/	If preterm delivery ( >24		Baby cried	Referred to	Any		Breast feeding	Birth	Dose <sup>467</sup> (G	ven/Not G	iven)
	Preterm	If preterm delivery ( >24 weeks & < 34 weeks) inj. corticosteriods	Sex of infant (M/F)	illillediately	higher facility for further	defect seen at	Weight at	started within one	OPV	BCG	HEP B	VIT K <sup>468</sup>
Sr. No. of the baby		given to mother (Yes/No/Don't Know)	illialit (W/F)	at birth (Yes/No)	management (Yes/No/NA)	birth <sup>466</sup>	birth (Kg)	hour of birth (Yes/No)	Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

<sup>466 (</sup>A) CLEFT LIP/ CLEFT PALATE, (B) NEURAL TUBE DEFECT (SPINA BIFIDA), (C) CLUB FOOT, (D) HYDROCEPHALUS, (E) IMPERFORATE ANUS, (F) DOWN'S SYNDROME, (G) ANY OTHER(SPECIFY), (H) NIL 467 AT THE TIME OF BIRTH
468 INJ. VITABRIS INTRAMUSCULAR - (IF BIRTH WEIGHT > 1000 gm (DOSE-1.0 mg) & IF BIRTH WEIGHT < 1000 gm (DOSE- 0.5 mg)

NA - NOT APPLICABLE

65	66	67	68	69	70	71	72				
Sr. No.	Name of Mother	Post Natal Care (PNC)									
		PNC Visit after	Date of PNC Visit	No. of IFA Tabs given to	Indicate danger						
		Delivery <sup>469</sup>		mother/Nil	Mother <sup>470</sup>	Infant <sup>471</sup>	Weight of infant <sup>472</sup> (Kg)				
		1st Day									
		3rd Day									
		7th Day									
		42 nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									
		1st Day									
		3rd Day									
		7th Day									
		42nd Day									

<sup>469</sup> ROUTINE 4 PNC VISITS ON 1ST, 3RD, 7TH & 42ND DAY OF THE DELIVERY. UNDER HOME BASED NEWBORN CARE, THREE MORE VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY ARE REQUIRED (WRITE DETAILS IN PW-4 A FORMAT) 470 (A) PPH, (B) FEVER, (C) SEPSIS, (D) SEVERE ABDOMINAL PAIN, (E) SEVERE HEADACHE OR BLURRED VISION, (F) DIFFICULT BREATHING, (G) FEVER/ CHILLS, (H) OTHER -SPECIFY, (I) NIL. IF YES - REFER TO FACILITY,

<sup>471 (</sup>A) JAUNDICE, (B) DIARRHOEA, (C) VOMITING, (D) FEVER, (E) HYPOTHERMIA (COLD BODY), (F) CONVULSIONS, (G) CHEST - IN -DRAWING (FAST BREATHING), (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL. IF ANY ONE IS YES, REFER TO HEALTH FACILITY



73	74	75	76	77	78	79	80	81
If danger sign (s) present for mother or infant, indicate place & name of referral facility		Indicate post partum contraception method being used			bable cause of Mother Deat		Place of death (Home/Hospital/ In	Remarks (If any)
Mother	Infant		Cause	Date	Cause Date		Transit)	` ,

### SECTION-II

## Tracking of Pregnant Women

		UNDER HOME BASED NEWBORN CARE	(HBNC) THREE MORE VISI	TS ON 14TH, 21ST , & 28TH D	AY OF DELIVERY ARE R	EQUIRED				
82	83	84	85	86		87				
Sr. No.	Name of Mother	Post Natal Care (PNC)								
		PNC Visit <sup>473</sup> After Delivery	Date of PNC Visit	No. of IFA Tabs given	Indicate dange					
				to mother/Nil	Mother <sup>474</sup>	Infant <sup>475</sup>	Weight of infant <sup>476</sup>			
		14th Day								
		21st Day								
		28th Day								
		14th Day								
		21st Day								
		28th Day 14th Day								
		21st Day								
		28th Day								
		14th Day								
		21st Day								
		28th Day								

<sup>473</sup> UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
474 (A) PPH (B) FEVER (C) SEPSIS (D) SEVERE ABDOMINAL PAIN (E) SEVERE HEADACHE OR BLURRED VISION (F) DIFFICULT BREATHING (G) FEVER/ CHILLS (H) OTHER -SPECIFY, (I) NIL . IF YES - REFER TO FACILITY

<sup>475 (</sup>A) JAUNDICE (B) DIARRHOEA (C)VOMITING (D)FEVER (E) HYPOTHERMIA (COLD BODY) (F) CONVULSIONS (G) CHEST -IN -DRAWING (FAST BREATHING) (H) DIFFICULTY IN FEEDING /UNABLE TO SUCK /DECREASED MOVEMENTS, (I) NIL . IF ANY ONE IS YES, REFER TO HEALTH FACILITY

<sup>476</sup> DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

PW - 4

		Haokii	ig of Fregulatic Wolf			PVV - 4 A				
	UNDER HOME BASED NEWBORN CARE (HBNC) THREE MORE VISITS ON 14TH, 21ST , & 28TH DAY OF DELIVERY ARE REQUIRED									
88		89	90	91	92	93				
If danger sign (s) present for mother or infant, indicate place & name of referral facility 477		Indicate post partum contraception method being used 478 If died, date and pro Infant Death 479		bable cause of death  Mother Death  **The company of the company o	Place of death (Home/Hospital/ In Transit)	Remarks (If any)				
Mother	Infant									

<sup>477 (</sup>A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)

<sup>478 (</sup>A) POST PARTUM IUCD (PPIUCD- WITHIN 48 HOURS OF DELIVERY) (B) CONDOM (C) STERILIZATION (MALE) (D) POST PARTUM STERILIZATION (PPS-WITHIN 7 DAYS OF DELIVERY) (E) NONE (F) ANY OTHER (SPECIFY)

<sup>479</sup> PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)

<sup>480</sup> PROBABLE CAUSE OF MATERNAL DEATH (ECLAMPSIA, HAEMORRHAGE (PPH), ANAEMIA, HIGH FEVER, OTHER (SPECIFY) NOTE: AFTER 42 DAYS OF DELIVERY, SHIFT BACK TO EC -2 FORMAT AND TRACK THE ELIGIBLE COUPLE FOR USE OF CONTRACEPTIVES.