Section II

Tracking of Pregnant Women

SECTION-II (INDEX)

Tracking of Pregnant Women

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[1]**
Sr. No.	**MCTS ID No. of Pregnant Woman[2]**	**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)**	

1 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[3]**
Sr. No.	**MCTS ID No. of Pregnant Woman[4]**	**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)**	

3 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

4 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[5]**
Sr. No.	**MCTS ID No. of Pregnant Woman[6]**	**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)**	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

5 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[7]**
Sr. No.	**MCTS ID No. of Pregnant Woman[8]**	**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)**	
1									
2									
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7									
8									
9									
10									

7 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[9]**
Sr. No.	**MCTS ID No. of Pregnant Woman[10]**	**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)**	
1									
2									
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6									
7									
8									
9									
10									

9 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[11]**
Sr. No.	**MCTS ID No. of Pregnant Woman[12]**	**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)**	
1									
2									
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6									
7									
8									
9									
10									

11 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[13]**
Sr. No.	**MCTS ID No. of Pregnant Woman[14]**	**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)**	
1									
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6									
7									
8									
9									
10									

13 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
14 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[15]**
Sr. No.	**MCTS ID No. of Pregnant Woman[16]**	**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)**	
1									
2									
3									
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5									
6									
7									
8									
9									
10									

15 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

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[17]**
Sr. No.	**MCTS ID No. of Pregnant Woman[18]**	**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)**	
1									
2									
3									
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6									
7									
8									
9									
10									

17 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

18 ID NO. OF PREGNANT WOMAN WILL BE SAME AS RESPECTIVE MCTS ID NO. OF THE WOMAN UNDER SECTION- I OF THIS REGISTER

SECTION-II (INDEX)

1	2	3	4	5			6		7
							**JSY Beneficiary Details**		**Page Number[19]**
Sr. No.	**MCTS ID No. of Pregnant Woman[20]**	**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)**	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

19 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

SECTION-II (INDEX)

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration
1.											
2.											
3.											
4.											

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

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD(1)	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness(2)	Past Obstetrics History				Indicate expected place and name of facility for delivery(5)	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done(6)
						Total No. of Pregnancy	Details of last two Pregnancy	Complications(3)	Outcome of Pregnancy(4)			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

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

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details

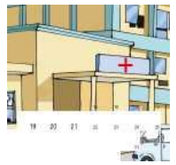




34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks of pregnancy) [4]/ Nil given [23] [24]	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdomen examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd / Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/ Absent)				

(3) 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)

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



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [25]	Who Conducted Delivery[26]	Type of Deliver[27]	Complication During Delivery[28]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

25 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
26 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
27 NORMAL / CAESAREAN / ASSISTED
28 (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 — PW - 3

Infant Details

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

29 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[32]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[33]	Infant[34]	Weight of infant[35] (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					

32 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)

33 (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,

34 (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

35 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[36] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[37]	Infant[38]	Weight of infant[39]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

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

37 (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

38 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[40]		Indicate post partum contraception method being used[41]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[42]	Mother Death[43]		
Mother	Infant					

40 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
41 (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)
42 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
43 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration
5.											
6.											
7.											
8.											

44SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
45IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

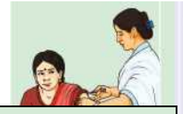
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given [46] [47]	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

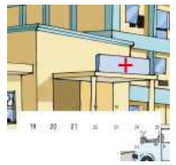
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 µgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

SECTION-II

Tracking of Pregnant Women

PW - 3



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [48]	Who Conducted Delivery[49]	Type of Deliver[50]	Complication During Delivery[51]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

48 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
49 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
50 NORMAL / CAESAREAN / ASSISTED
51 (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 — PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[52]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[53] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[54]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

52 (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
53 AT THE TIME OF BIRTH
54 INJ. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[55]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[56]	Infant[57]	Weight of infant[58] (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					

55 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)

56 (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,

57 (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

58 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II
Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[59] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[60]	Infant[61]	Weight of infant[62]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

59 UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
60 (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
61 (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
62 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[63]		Indicate post partum contraception method being used[64]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[65]	Mother Death[66]		

63 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
64 (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)
65 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
66 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information

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 LMP	Date of Registration

67SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
68IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)**	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)(2)**			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

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

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)	
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster

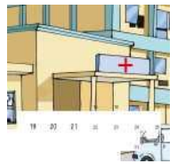
37

No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given [69] [70]

38	39				40	41	42	
No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
	Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/ Absent)				

(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 μgm) (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)
70 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



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [71]	Who Conducted Delivery[72]	Type of Deliver[73]	Complication During Delivery[74]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

71 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
72 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
73 NORMAL / CAESAREAN / ASSISTED
74 (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

PW - 3

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

75 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[78]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[79]	Infant[80]	Weight of infant[81] (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					

78 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)

79 (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,

80 (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

81 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[82] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[83]	Infant[84]	Weight of infant[85]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

82 UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
83 (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
84 (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
85 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[86]		Indicate post partum contraception method being used[87]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[88]	Mother Death[89]		

86 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
87 (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)
88 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
89 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

90SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
91IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

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

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given [92] [93]	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/ Absent)				

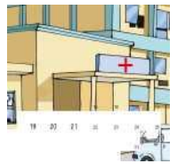
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 µgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

93 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	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [94]	Who Conducted Delivery[95]	Type of Deliver[96]	Complication During Delivery[97]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

94 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
95 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
96 NORMAL / CAESAREAN / ASSISTED
97 (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 — PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[98]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[99] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[100]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

98 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[101]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[102]	Infant[103]	Weight of infant[104] (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					

101 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)

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

104 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[105] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[106]	Infant[107]	Weight of infant[108]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

105 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
107 (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
108 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[109]		Indicate post partum contraception method being used[110]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[111]	Mother Death[112]		
Mother	Infant					

109 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
110 (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)
111 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
112 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

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

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

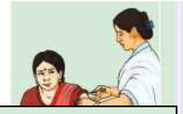
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given [115] [116]	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

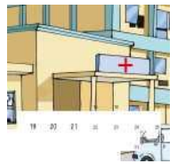
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 µgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

SECTION-II

Tracking of Pregnant Women

PW - 3



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [117]	Who Conducted Delivery[118]	Type of Deliver[119]	Complication During Delivery[120]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

117 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
118 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
119 NORMAL / CAESAREAN / ASSISTED
120 (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

PW - 3

Infant Details

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

121 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[124]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[125]	Infant[126]	Weight of infant[127] (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					

124 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)

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

127 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[128] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[129]	Infant[130]	Weight of infant[131]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

128 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

130 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[132]		Indicate post partum contraception method being used[133]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[134]	Mother Death[135]		
Mother	Infant					

132 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
133 (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)
134 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
135 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.

SECTION-II
Tracking of Pregnant Women PW . 1

General Information






1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	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 LMP	Date of Registration

136SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
137IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

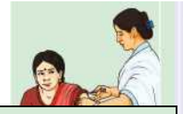
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 138 139	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 µgm) (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)

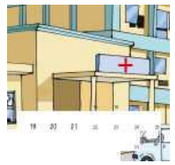
139 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

SECTION-II

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [140]	Who Conducted Delivery[141]	Type of Deliver[142]	Complication During Delivery[143]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

140 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
141 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
142 NORMAL / CAESAREAN / ASSISTED
143 (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 — PW - 3

Infant Details

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

144 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[147]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[148]	Infant[149]	Weight of infant[150] (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					

147 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,

149 (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

150 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[151] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[152]	Infant[153]	Weight of infant[154]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

151 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
153 (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
154 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[155]		Indicate post partum contraception method being used[156]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[157]	Mother Death[158]		
Mother	Infant					

155 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
156 (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)
157 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
158 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

159SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
160IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)**	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)(2)**			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

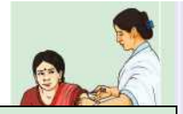
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details



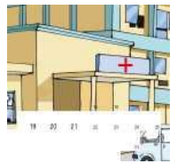


34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 161 162	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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

Tracking of Pregnant Women



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [163]	Who Conducted Delivery[164]	Type of Deliver[165]	Complication During Delivery[166]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

163 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
164 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
165 NORMAL / CAESAREAN / ASSISTED
166 (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 — PW - 3

Infant Details												
Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteroids given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[167]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[168] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[169]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

167 (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

65	66	67	68	69	70	71	72
Sr. No.	Name of Mother	Post Natal Care (PNC)					
		PNC Visit after Delivery[170]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[171]	Infant[172]	Weight of infant[173] (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					

170 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,

172 (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

173 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[174] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[175]	Infant[176]	Weight of infant[177]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

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

175 (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

176 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[178]		Indicate post partum contraception method being used[179]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[180]	Mother Death[181]		

178 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
179 (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)
180 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
181 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.

SECTION-II
Tracking of Pregnant Women PW . 1

General Information






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 LMP	Date of Registration

182SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
183IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

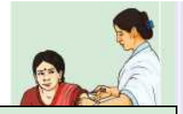
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 184 185	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

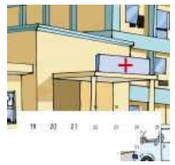
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [186]	Who Conducted Delivery[187]	Type of Deliver[188]	Complication During Delivery[189]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

186 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
187 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
188 NORMAL / CAESAREAN / ASSISTED
189 (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

PW - 3

Infant Details

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

190 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[193]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[194]	Infant[195]	Weight of infant[196] (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					

193 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)

194 (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

196 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[197] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[198]	Infant[199]	Weight of infant[200]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

197 UNDER HBNC THREE ADDITIONAL VISITS ON 14TH, 21ST, & 28TH DAY OF DELIVERY
198 (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
199 (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
200 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[201]		Indicate post partum contraception method being used[202]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[203]	Mother Death[204]		
Mother	Infant					

201 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
202 (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)
203 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
204 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

205SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
206IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

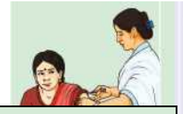
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details



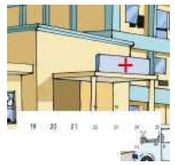


34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 207 208	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 µgm) (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

Tracking of Pregnant Women



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [209]	Who Conducted Delivery[210]	Type of Deliver[211]	Complication During Delivery[212]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

209 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
210 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
211 NORMAL / CAESAREAN / ASSISTED
212 (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

PW - 3

Infant Details

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

213 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[216]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[217]	Infant[218]	Weight of infant[219] (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					

216 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,

218 (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

219 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[220] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[221]	Infant[222]	Weight of infant[223]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

220 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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[224]		Indicate post partum contraception method being used[225]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[226]	Mother Death[227]		

224 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
225 (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)
226 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
227 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

228SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
229IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)[2]			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

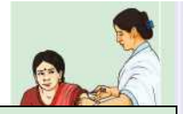
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details



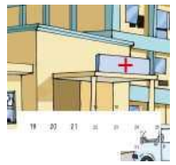


34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 230 231	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

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

Tracking of Pregnant Women



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [232]	Who Conducted Delivery[233]	Type of Deliver[234]	Complication During Delivery[235]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

232 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
233 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
234 NORMAL / CAESAREAN / ASSISTED
235 (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 — PW - 3

Infant Details

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

236 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[239]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[240]	Infant[241]	Weight of infant[242] (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					

239 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)

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

242 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[243] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[244]	Infant[245]	Weight of infant[246]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

243 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

245 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[247]		Indicate post partum contraception method being used[248]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[249]	Mother Death[250]		

247 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
248 (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)
249 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
250 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

251SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
252IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 [1]	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)[2]			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

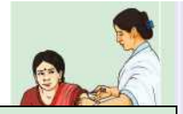
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 253 254	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

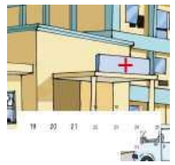
254 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

SECTION-II

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [255]	Who Conducted Delivery[256]	Type of Deliver[257]	Complication During Delivery[258]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

255 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
256 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
257 NORMAL / CAESAREAN / ASSISTED
258 (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

PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[259]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[260] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[261]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

259 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[262]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[263]	Infant[264]	Weight of infant[265] (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					

262 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)

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

265 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[266] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[267]	Infant[268]	Weight of infant[269]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

266 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

268 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[270]		Indicate post partum contraception method being used[271]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[272]	Mother Death[273]		

270 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
271 (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)
272 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
273 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

274SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
275IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)**	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)(2)**			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

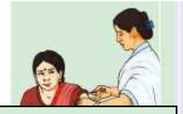
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 276 277	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

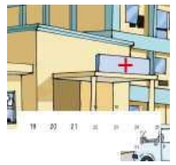
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

SECTION-II

Tracking of Pregnant Women

PW - 3



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [278]	Who Conducted Delivery[279]	Type of Deliver[280]	Complication During Delivery[281]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

278 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
279 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
280 NORMAL / CAESAREAN / ASSISTED
281 (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

PW - 3

Infant Details

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

282 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[285]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[286]	Infant[287]	Weight of infant[288] (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					

285 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)

286 (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,

287 (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

288 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[289] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[290]	Infant[291]	Weight of infant[292]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

289 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

291 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[293]		Indicate post partum contraception method being used[294]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[295]	Mother Death[296]		

293 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
294 (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)
295 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
296 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

297SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
298IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

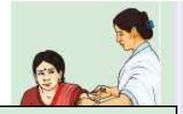
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 299 300	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

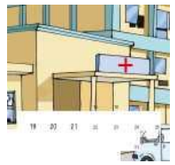
300 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

SECTION-II

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [301]	Who Conducted Delivery[302]	Type of Deliver[303]	Complication During Delivery[304]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

301 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
302 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
303 NORMAL / CAESAREAN / ASSISTED
304 (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 — PW - 3

Infant Details

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

305 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[308]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[309]	Infant[310]	Weight of infant[311] (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					

308 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,

310 (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

311 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[312] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[313]	Infant[314]	Weight of infant[315]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

312 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
314 (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
315 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[316]		Indicate post partum contraception method being used[317]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[318]	Mother Death[319]		
Mother	Infant					

316 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
317 (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)
318 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
319 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.

SECTION-II
Tracking of Pregnant Women PW . 1

General Information

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 LMP	Date of Registration

320SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
321IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 [1]	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)[2]			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

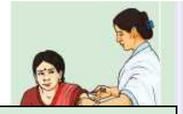
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 322 323	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

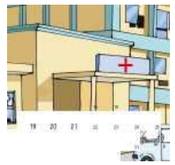
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [324]	Who Conducted Delivery[325]	Type of Deliver[326]	Complication During Delivery[327]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

324 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
325 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
326 NORMAL / CAESAREAN / ASSISTED
327 (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

PW - 3

					Infant Details							
Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[328]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[329] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[330]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

328 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[331]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[332]	Infant[333]	Weight of infant[334] (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					

331 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)

332 (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 mother or infant, indicate place & name of referral facility		Indicate post partum contraception method being used	If died, date and probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[335] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[336]	Infant[337]	Weight of infant[338]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

335 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

337 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[339]		Indicate post partum contraception method being used[340]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[341]	Mother Death[342]		
Mother	Infant					

339 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
340 (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)
341 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
342 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

343SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
344IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)**	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)(2)**			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

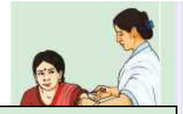
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 345 346	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

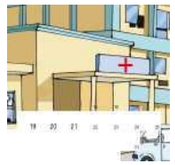
346 IN CASE OF "SICKLE CELL ANAEMIA", DO NOT GIVE FOLIC ACID /IFA, REFERE TO HIGHER FACILITY. FOETAL PRESENTATION (NORMAL / TRANSVERSE) P: PRESENT, A: ABSENT

SECTION-II

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [347]	Who Conducted Delivery[348]	Type of Deliver[349]	Complication During Delivery[350]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

347 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
348 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
349 NORMAL / CAESAREAN / ASSISTED
350 (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 — PW - 3

Infant Details

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

351 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[354]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[355]	Infant[356]	Weight of infant[357] (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					

354 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,

356 (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

357 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[358] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[359]	Infant[360]	Weight of infant[361]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

358 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

360 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[362]		Indicate post partum contraception method being used[363]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[364]	Mother Death[365]		

362 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
363 (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)
364 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
365 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

366SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
367IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

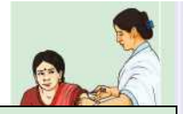
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





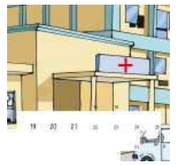
34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 368 369	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

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

Tracking of Pregnant Women

PW - 3



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [370]	Who Conducted Delivery[371]	Type of Deliver[372]	Complication During Delivery[373]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

370 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
371 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
372 NORMAL / CAESAREAN / ASSISTED
373 (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

PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[374]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[375] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[376]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

374 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[377]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[378]	Infant[379]	Weight of infant[380] (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					

377 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,

379 (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

380 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[381] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[382]	Infant[383]	Weight of infant[384]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

381 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
383 (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
384 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[385]		Indicate post partum contraception method being used[386]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[387]	Mother Death[388]		

385 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
386 (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)
387 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
388 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.

SECTION-II
Tracking of Pregnant Women

PW . 1

General Information






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 LMP	Date of Registration

389SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
390IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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-II

Tracking of Pregnant Women

PW - 2

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

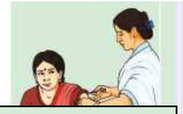
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 391 392	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

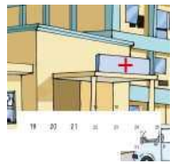
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

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

Tracking of Pregnant Women

PW - 3





43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [393]	Who Conducted Delivery[394]	Type of Deliver[395]	Complication During Delivery[396]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

393 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
394 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
395 NORMAL / CAESAREAN / ASSISTED
396 (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 — PW - 3

Infant Details

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

397 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[400]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[401]	Infant[402]	Weight of infant[403] (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					

400 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)

401 (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) 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

403 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[404] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[405]	Infant[406]	Weight of infant[407]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

404 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

406 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[408]		Indicate post partum contraception method being used[409]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[410]	Mother Death[411]		
Mother	Infant					

408 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
409 (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)
410 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
411 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

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

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)	Date of ANC	Facility/ Place/Site of ANC done	No. of weeks of pregnancy	Abortion (if any)(2)			Wt. of PW (Kg)	BP mm Hg		Hb (gm%)
						No	If Yes, (I/S) No. of weeks of pregnancy	If induced, abortion indicate facility (Govt./Pvt.)		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.

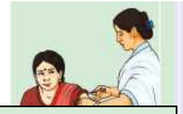
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details





34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 414 415	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

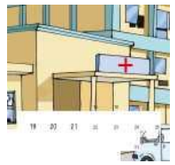
(3) IF SUGAR PRESENT IN URINE, ADVISE BLOOD SUGAR TEST FROM NEAREST HEALTH FACILITY. (4) TAB. FOLIC ACID (400 |jgm) (WITHIN 12 WEEKS OF PREGNANCY) (5) TAB IFA (AFTER 12 WEEKS OF PREGNANCY). IF ANAEMIC, GIVE DOUBLE DOSE OF IFA. IF TAB. IFA IS NOT GIVEN, WRITE 'NIL' . (6) (A) HIGH BP (SYSTOLIC > 140 AND 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)

415 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	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [416]	Who Conducted Delivery[417]	Type of Deliver[418]	Complication During Delivery[419]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

416 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
417 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
418 NORMAL / CAESAREAN / ASSISTED
419 (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

PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[420]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[421] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[422]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

420 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[423]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[424]	Infant[425]	Weight of infant[426] (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					

423 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)

424 (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 mother or infant, indicate place & name of referral facility		Indicate post partum contraception method being used	If died, date and probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[427] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[428]	Infant[429]	Weight of infant[430]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

427 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

429 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[431]		Indicate post partum contraception method being used[432]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[433]	Mother Death[434]		

431 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
432 (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)
433 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
434 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

435SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
436IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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 (1)**	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)(2)**			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

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

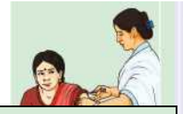
33!

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details



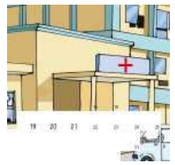


34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 437 438	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

438 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



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [439]	Who Conducted Delivery[440]	Type of Deliver[441]	Complication During Delivery[442]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

439 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
440 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
441 NORMAL / CAESAREAN / ASSISTED
442 (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

PW - 3

Infant Details

Sr. No. of the baby	Full term/ Preterm	If preterm delivery (>24 weeks & < 34 weeks) inj. corticosteriods given to mother (Yes/No/Don't Know)	Sex of infant (M/F)	Baby cried immediately at birth (Yes/No)	Referred to higher facility for further management (Yes/No/NA)	Any defect seen at birth[443]	Weight at birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose[444] (Given/Not Given)			
									OPV	BCG	HEP B	VIT K[445]
									Date	Date	Date	Date
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												
BABY 1												
BABY 2												

443 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[446]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[447]	Infant[448]	Weight of infant[449] (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					

446 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

449 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[450] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[451]	Infant[452]	Weight of infant[453]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

450 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
452 (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
453 DURING EACH PNC VISIT, TAKE WEIGHT OF THE INFANT, IF NO GAIN IN WEIGHT/ LOSS IN WEIGHT, REFERE TO HEALTH FACILITY

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[454]		Indicate post partum contraception method being used[455]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death[456]	Mother Death[457]		
Mother	Infant					

454 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
455 (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)
456 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
457 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.

SECTION-II
Tracking of Pregnant Women

General Information






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 LMP	Date of Registration

458SAME AS RESPECTIVE MCTS ID NO. UNDER SECTION-I
459IF NAME OF HUSBAND IS NOT DISCLOSED, WRITE NOT APPLICABLE

SECTION-II
Tracking of Pregnant Women

PW - 1

General Information

13	14	15	16	17	18	19				20	21	22
No. of weeks of pregnancy at the time of registration	Registered within 12 weeks of pregnancy (Yes/No)	Weight of PW (KG) at the time of registration	EDD[1]	Blood Group of PW [Done (Result)/ Not Done]	Past H/O Illness[2]	Past Obstetrics History				Indicate expected place and name of facility for delivery[5]	VDRL (RPR) test done (date) + VE/VE / Not done	HIV screening test done (date) test - VE / not done[6]
						Total No. of Pregnancy	Details of last two Pregnancy	Complications (3)	Outcome of Pregnancy[4]			
							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

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** [1]	**Date of ANC**	**Facility/ Place/Site of ANC done**	**No. of weeks of pregnancy**	**Abortion (if any)**[2]			**Wt. of PW (Kg)**	**BP mm Hg**		**Hb (gm%)**
						No	**If Yes, (I/S) No. of weeks of pregnancy**	**If induced, abortion indicate facility (Govt./Pvt.)**		**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.

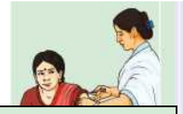
(2) INDUCED /SPONTANEOUS (I= INDUCED, S= SPONTANEOUS)

SECTION-II
Tracking of Pregnant Women

PW - 2

Ante Natal Care (ANC) Details



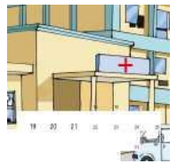


34		35		36		37	38	39				40	41	42	
Urine Test (Done/Not Done)		Blood Sugar Test (Done/Not Done)		TT Dose (Date)		No. of Folic Acid Tabs** (within 12 weeks [4]/ Nil of pregnancy) given 460 461	No of IFA Tabs given (after 12 weeks)[5]	Fundal/Abdoman examination				Any symptom of high risk[6] please indicate	Date, type & name of referral facility[7]	Maternal death (No/Yes)	If died, date, place & probable cause[8]
Albumin (P/A)	Sugar [3] (P/A)	If done Fasting	If done Post Prandial	Ist	2nd/ Booster			Fundal Height/ Size of the uterus	Foetal heart rate	Foetal presentation /Position	Foetal movements (Normal/Increased/ Decreased/				

(3) 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)

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

Tracking of Pregnant Women



43	44	45	46	47	48	49	50	51	
Sr. No.	Delivery Outcome								
	Name of PW	Date & Time (HH:MM) of Delivery	Place of Delivery [462]	Who Conducted Delivery[463]	Type of Deliver[464]	Complication During Delivery[465]	Out come of delivery: Live birth (1/2) or Still birth (1/2)	Date & Time of Discharge (If Institutional Delivery)	
								(DD/MM/YYYY)	Time (HH:MM)

462 DISTT. HOSP/CHC/PHC/ SUB-CENTER/OTHER PUBLIC FACILITY/ACCREDITED PVT. HOSP./ OTHER PVT. HOSP/ HOME
463 ANM /LHV/ DOCTOR/ STAFF NURSE / RELATIVE/ OTHER (SPECIFY)
464 NORMAL / CAESAREAN / ASSISTED
465 (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

PW - 3

Infant Details

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

466 (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. VITAMIN K3- INTRAMUSCULAR - (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 Care (PNC)					
		PNC Visit after Delivery[469]	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger Sign(s) (If any)		
					Mother[470]	Infant[471]	Weight of infant[472] (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					

469 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,

471 (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

472 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 probable cause of death				Place of death (Home/Hospital/ In Transit)	Remarks (If any)
			Infant Death		Mother Death			
Mother	Infant		Cause	Date	Cause	Date		

SECTION-II

Tracking of Pregnant Women

PW - 4 A

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	Post Natal Care (PNC)					
		PNC Visit[473] After Delivery	Date of PNC Visit	No. of IFA Tabs given to mother/Nil	Indicate danger sign (s) (If any)		
					Mother[474]	Infant[475]	Weight of infant[476]
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					
		14th Day					
		21st Day					
		28th Day					

473 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

475 (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

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

SECTION-II

Tracking of Pregnant Women

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 mother or infant, indicate place & name of referral facility[477]		Indicate post partum contraception method being used[478]	If died, date and probable cause of death		Place of death (Home/Hospital/ In Transit)	Remarks (If any)
Mother	Infant		Infant Death[479]	Mother Death[480]		

477 (A) PHC (B) CHC (C) DISTRICT HOSP. (D). PRIVATE HOSP./ OTHER (SPECIFY)
478 (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)
479 PROBABLE CAUSE OF INFANT DEATH (ASPHYXIA, LOW BIRTH WEIGHT, FEVER, DIARRHOEA, PNEUMONIA, ANY OTHER -SPECIFY)
480 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.