**FACILITY BASED CHILD DEATH (1month-5 years) REVIEW FORM**

1. Attach a copy of the case records to this form.

2. Complete the form in duplicate within one week of child’s death. The original should be maintained in records at the institution where the death occurred ;one copy should be forwarded to the District Nodal Officer.

-------------------------------------------------------------------------------------------------------------

**For Office Use Only**:

|  |  |
| --- | --- |
| FB –CDRNO: | Year |

**Name & Address of the facility where death occurred:**

(Including State, District, Block)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **DETAILS OF DECEASED** | |
| **Inpatient Number/ID** |  |
| **Age** | **Years ……Months ……** |
| **Sex** | **Male □ Female □** |
| **Name** |  |
| **Name of the Mother** |  |
| **Address (including Block/Tehsil, District/Taluq/Division, State)** |  |
| **Date of birth** |  |
| **Place of birth (Health Facility/Home)** | **Health facility □ Home □** |
| **Birth weight (if available on record)** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_kgs.** |
| **Date of admission** |  |
| **Time of admission** |  |
| **Date of death** |  |
| **Time of death** |  |
| **Death certified by :**  **(name & designation of the doctor)** |  |

**[[**

|  |  |
| --- | --- |
| **Type of facility where death took place** | **□Sub district hospital/Taluq hospital**  **□CHC □DH**  **□Referral Hospital □Medical college/tertiary hospital** |
| **Main complaints at the time of admission Duration**  **Inability to drink or feed Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Fever Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Loose stools Number of days \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Vomiting Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Cough or difficult breathing Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Convulsions Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Lethargic or unconscious Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Appearance of Skin rashes Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Bleeding Number of days \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Injury (like fractures, wounds) Number of days \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Unknown bites or stings**  **Any other symptom** | |
| **Weight on admission:** | **kgs.** |
| **Immunisation history:** | **Complete/ Incomplete (If incomplete give details)** |
| **Condition on Admission** | |
| **Breathing** | **□Normal breathing □Severe chest in drawing**  **□Central cyanosis □Not breathing or gasping** |
| **Consciousness level** | **□ Stable □ Convulsions □ Unconscious**  **□ Semi-conscious, responds to verbal commands**  **□ Semi-conscious, responds to painful stimuli** |
| **Circulation** | **□Eextremities:warm to touch / colder than the abdomen**  **□Weak and fast pulse: whether 1+/2+/3+**  **□Capillary Refill Time: □<3 seconds □>3seconds** |
| **Other symptoms** | **□Dehydration □Bleeding □Icterus**  **□Petechial rashes or bruising □Trauma/ urgent surgical condition**  **□Burns □Oedema of both feet □ Severe wasting**  **□Ear Discharge □ Severe cyanosis** |
| **Total Duration of stay in the health facility** | **□<48 hours □48 hours -7 days □8-14 days □14-21 days**  **□More than 21 days** |
| **Investigations** | **□Blood glucose**  **□CBC**  **□Urine test**  **□ Renal function tests**  **□ CSF**  **□ Widal test**  **□ Serum bilirubin**  **□Blood culture**  **□Liver Function Test**  **□Urine culture**  **□ Others (specify)** |
| **REFERRAL DETAILS** | |
| Was the child referred from another Centre? | Yes/ No /Don’t know |
| If yes, Type of facility from which referred? | ☐24x7PHC ☐SDH/Rural Hospital/CHC  ☐District Hospital ☐Private Hospital  ☐Private clinic ☐medical college/Specialty Hospitals ☐Others |

**TREATMENT DETAILS**

|  |  |
| --- | --- |
| Oxygen use | **Yes No** |
| IV Fluids | **Yes No** |
| Antibiotics | **Yes No** |
| Anti malarials | **Yes No** |
| Anticonvulsants | **Yes No** |
| Bronchodilators | **Yes No** |
| Blood Components | **Yes No** |
| Steroids | **Yes No** |
| Anti tubercular drugs | **Yes No** |
| Antiretroviral drugs | **Yes No** |
| Vasopressors (Dopamine/Dobutamine/Adrenaline) | **Yes No** |
| Respiratory support (CPAP/Ventilator) | **Yes No** |
| Surgical interventions | **Yes No** |
| Other interventions (provide details) |  |

**DIAGNOSIS**

|  |  |
| --- | --- |
| At admission |  |
| By Certifying doctor  (**Diagnosis , immediately at the time of death, by the Medical Officer on duty)** |  |
| By Treating doctor ( Within one week)  **(Final Diagnosis by the doctor under whose primary care the child was admitted in the hospital)** | |
| Probable direct cause of death |  |
| Indirect cause of death |  |
| Final Diagnosis |  |

**Signature of the certifying doctor**

Name

Designation

Stamp & Date:

**Signature of the treating doctor**

Name

Designation

Stamp & Date

**Verified by Nodal Officer /Administrative In charge of the Hospital:**

Signature

Name

Designation

Stamp and Date