**FACILITY BASED NEWBORN DEATH (upto 28 days) 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.

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**For Office Use Only**:

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| FB –IDR NO: | Year |

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

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

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| **DETAILS OF DECEASED** | |
| **Inpatient Number/ID** |  |
| **Age** |  |
| **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)** |  |

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| **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\_\_\_\_\_\_\_\_\_\_\_\_\_  Appearance of Skin rashes Number of days\_\_\_\_\_\_\_\_\_\_\_\_\_  Injury (like fractures, wounds) Number of days \_\_\_\_\_\_\_\_\_\_\_\_\_  Lethargic  Stiffness of neck  Bluish discoloration of lips, nails  Skin pustules of yellow colour  Any other symptom | | |
| **Weight on admission:** | **kgs.** | |
| **Immunisation history:** | **Complete/ Incomplete (If in complete details)** | |
| **Condition on Admission** | | |
| **Breathing** | **□Normal breathing □Severe chest in drawing**  **□Central cyanosis □Not breathing or gasping** | |
| **Consciousness level** | **□ Alert, responds to normal stimuli**  **□ Semi-conscious, responds to painful stimuli**  **□ High pitched cry/ Persistent crying/ Inability to suck**  **□ Unconscious** | |
| **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**  **□Congenital malformation □Budging fontanels**  **□ Hypothermia □Hyperthermia □ Sclerema** | |
| **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**  **□Sepsis screen**  **□ Renal function tests**  **□ CSF**  **□ Urine test**  **□ CRP**  **□ 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 | |
| **INTRAPARTUM AND POST PARTUM DETAILS (ONLY FOR INBORN BABIES)** | | |
| **Onset of labour** | | ☐ Spontaneous ☐ Induced ☐ Unknown |
| Gestational Age | | ☐Term ☐ Preterm (Specify POG………………..) ☐ Post term |
| Mode of delivery | | ☐ Spontaneous vaginal ☐ Vacuum/ Forceps ☐ Caesarian section |
| Whether any complications during labour | | ☐ PROM ☐ Sepsis ☐ Eclampsia ☐ Obstructed labour ☐ Others specify |
| Was Patograph used | | ☐ Yes ☐ No ☐ DNK |
| Birth weight | |  |
| Resuscitation at birth | | ☐ Yes ☐ No ☐ DNK |
| If yes, who resuscitated the newborn? | | ☐ Pediatrician ☐ Obstetrician ☐ MBBS/ Other doctor ☐ Staff nurse ☐ Other specify |
| APGAR score( if given at birth) | |  |

**TREATMENT DETAILS**

|  |  |
| --- | --- |
| Oxygen use | **Yes No** |
| Temperature control | **Yes No** |
| Antibiotics | **Yes No** |
| IV Fluids | **Yes No** |
| Anticonvulsants | **Yes No** |
| Bronchodilators | **Yes No** |
| Blood Components | **Yes No** |
| Steroids | **Yes No** |
| Vasopressors (Dopamine/Dobutamine/Adrenaline) | **Yes No** |
| Antiretroviral drugs | **Yes No** |
| Phototherapy | **Yes No** |
| Exchange blood transfusion | **Yes No** |
| Respiratory support (CPAP/Ventilator) | **Yes No** |
| Surgical interventions | **Yes No** |
| Other interventions (provide details) |  |

**DIAGNOSIS**

|  |  |
| --- | --- |
| Please tick appropriate age at time of death | ☐ Within 24 hrs. ☐ In first week (2-7 days)  ☐ In late neonatal period (8-28 days) |
| Provisional diagnosis at admission |  |
| Provisional diagnosis at time of death (by the doctor on duty) |  |
| Probable direct cause of death |  |
| Indirect cause of death |  |
| Final Diagnosis (**Final Diagnosis by the treating doctor under whose primary care the child was admitted in the hospital)** |  |

**Signature of the certifying doctor Signature of the treating doctor**

Name Name

Designation Designation

Stamp & Date: Stamp & Date

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

Signature

Name

Designation /Stamp and Date