Data Reporting Format-EC
FY: 2016-17

District: _____ Block: _____ Health Facility: _____

Sub Health Facility: _____ Village: _____

Name of Health Provider (ANM): _____ Name of ASHA : _____

Eligible Couples - Identification Details:

RCH ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Register S.No.: ☐☐☐

Name of Woman: _____ Name of Husband: _____

Aadhar No.: ☐☐☐☐☐☐☐☐☐☐☐☐ Account No.: _____

Bank Name: _____ Branch Name: _____ IFC Code: _____

Address: _____

Eligible Couples - Registration

Date of Registration*: d d m m y y

Current Age of Woman y y Current Age of Husband y y

Age at Marriage of Woman y y Age at Marriage of Husband y y

Category : ☐ BPL ☐ APL ☐ Not Known

Religion: ☐ Hindu ☐ Muslim ☐ Sikh ☐ Christian ☐ Other

Mobile Number :

☐ Woman/Self
☐ Husband
☐ Neighbor
☐ Relatives
☐ Others

EC- Other Information

Total No. of Children Born: ☐ Male ☐ Female ☐

No. of Live Children : ☐ Male ☐ Female ☐

Details of Youngest child: Age (Year) y y m m

Infertile Status : Yes ☐ No ☐ Referral Facility (FRU/DH) : ☐

Tracking of Eligible Couples and Use of Contraceptives:

Month	Method								
	(a) Condom	(b) OC Pills	(c) IUCD CU 380A [10 Yrs]	(d) IUCD CU 375	(e) Female Sterilization	(f) Male Sterilization	(g) EC Pills	(h) None	(i) Any other
April	dd/mm/yy								
May									
June									
July									
August									
September									
October									
November									
December									
January									
February									
March									

Pregnancy Test: Done ☐ Not Done ☐ Pregnancy Test Result: Negative ☐ Positive ☐

Signature of ANM : ☐ Signature of Supervisor : ☐

Data Reporting Format-PW
FY: 2016-17

District: _____ Block: _____ Health Facility: _____

Sub Health Facility: _____ Village: _____

Name of Health Provider (ANM): _____ Name of ASHA : _____

Pregnant Women - General Information:

MCTS ID: | | | | | | | | | | | | | | | | |

RCH ID: | | | | | | | | | | | | Sr. No. in RCH Register *: | | |

Name of Woman: _____ Name of Husband: _____

Address: _____

Aadhar No.: | | | | | | | | | | | | Account No.: _____

Bank Name: _____ IFC Code: _____

Caste: ☐ SC ☐ ST ☐ Other JSY Beneficiary: Yes / No

Religion: ☐ Hindu ☐ Muslim ☐ Sikh ☐ Christian ☐ Other Payment Received: Yes / No

Status: ☐ BPL ☐ APL ☐ Not Known Age of Pregnant Woman: y y

Pregnant Women - Registration Detail:

Date of Registration*: d d m m y y LMP Date*: d d m m y y

EDD*: d d m m y y Weight of PW (Kg)* : kg

No. of weeks of Pregnancy at the time of Registration : Yes / No

Registered within 12 Weeks of Pregnancy : Yes / No

Blood Group of PW : ☐ A (+Ve) ☐ B (+Ve) ☐ AB (+Ve) ☐ O (+Ve) ☐ A (-Ve) ☐ B (-Ve) ☐ AB (-Ve) ☐ O (-Ve)

Mobile Number : _____

☐ Woman/Self
☐ Husband
☐ Neighbor
☐ Relatives
☐ Others

Past illness : A TB B Diabetes C Hypertension D Heart Disease E Epileptic F STI/RTI G HIV(+VE) H Hepatitis-B I Asthma J Any other (Specify) _____ K None

Past Obstetrics History

Total No. Of Pregnancy : _____

Last two Pregnancy	Complication During Past Pregnancy
Last Pregnancy Outcome Of Pregnancy : ☐ Live Birth ☐ Still Birth ☐ Abortion	A Convulsions, B APH, C Pregnancy Induced Hypertension (PIH), D Repeated Abortion, E Still Birth, F Congenital Anomaly, G Caesarean Section, H Blood Trans., I Twins, J Obstructed Labour, K PPH Any, L Other (Specify) _____, L None
Last to Last Pregnancy Outcome Of Pregnancy : ☐ Live Birth ☐ Still Birth ☐ Abortion	A Convulsions, B APH, C Pregnancy Induced Hypertension (PIH), D Repeated Abortion, E Still Birth, F Congenital Anomaly, G Caesarean Section, H Blood Trans., I Twins, J Obstructed Labour, K PPH Any, L Other (Specify) _____, L None

Indicate expected place and name of facility for delivery

☐ DH ☐ CHC ☐ PHC ☐ Sub-Center ☐ Other Public Facility ☐ Acc. Pvt. Hospital
☐ Other Pvt. Hospital ☐ Home ☐ Sub District Hospital ☐ Medical College Hospital

Note Facility Name _____

Blood Examination	VDRL	HIV
☐ Done (Result)	☐ +VE ☐ –VE	☐ -VE ☐ Refer to ICTC
☐ Not Done		

Data Reporting Format-PW
FY: 2016-17

Pregnant Women - Tracking of Services:

Tracking of Pregnant Women					
ANC Service details		**1st Visit**	**2nd Visit**	**3rd Visit**	**4th Visit**
Date of ANC (dd/mm/yy)					
Facility/Place/Site of ANC Done					
No. of Weeks of pregnancy					
Abortion (if any)	*No*				
	If Yes (I/S) No. of weeks of pregnancy				
	If induced, abortion indicate facility (Govt./Pvt.)				
Wt. of PW (KG)					
Blood Pressure	*Systolic*				
	Diastolic				
HB (gm%)					
Urine Test	*Done/Not Done*				
	Albumin (P/A)				
	Sugar (P/A)				
Blood Sugar Test	*Fasting*				
	Post Prandial				
TT Dose (Date)	*1st(Date)*				
	2nd / Booster (Date)				
No. of Folic Acid Tabs (within 12 weeks of pregnancy)					
No. of IFA Tabs (after 12 weeks)					
Fundal/ Abdomen Examination	*Fundal Height/ Size of the uterus*				
	Foetal Heart Rate				
	Foetal presentation/ Position				
	Foetal movements (Normal/Increased/Decreased/ Absent)				
Any Symptom of high risk Please indicate					
Date, Type & name of referral facility	*(dd/mm/yy)*				
	Type & name of referral facility				
Contraceptive method would be used after this delivery					
Maternal Death	*Yes/No*				
	Date				
	Place of death				
	Probable cause				

Pregnant Women - Delivery Outcome:

Date of Delivery: d d m m y y Time of Delivery: H H : M M

Place of Delivery :
- ☐ DH
- ☐ CHC
- ☐ PHC
- ☐ Sub-Center
- ☐ Other Public Facility
- ☐ Acc. Pvt. Hospital
- ☐ Other Pvt. Hospital
- ☐ Home

Who Conducted Delivery :
☐ ANM ☐ LHV ☐ Doctor Staff Nurse
☐ Relative ☐ Other (Specify) _____

Type of Delivery :
☐ Normal ☐ Caesarean ☐ Assisted

Complication :
- ☐ (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 ☐ Hemorrhage ☐ Obstructed Labour
☐ Prolonged Labour ☐ Other (Specify) _____

Out Come of Delivery : _____ No. of Live Birth _____ No. of Still Birth _____

Date & Time of Discharge (If Institutional Delivery) Date : d d m m y y Time : H H : M M

Infant Details:

Infant Details	RCH ID	Full term / Preterm (Baby 1 / Baby 2)	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	Weight at Birth (Kg)	Breast feeding started within one hour of birth (Yes/No)	Birth Dose (Given date)			
									OPV	BCG	HEP-B	VIT-K
Baby-1												
Baby-2												

Data Reporting Format-PW
FY: 2016-17

District: _____ Block: _____ Health Facility: _____

Sub Health Facility: _____ Village: _____

Name of Health Provider (ANM): _____ Name of ASHA : _____

RCH ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Register S.No.: ☐☐☐

Name of Woman: _____ Name of Husband: _____

Post Natal Care (PNC)

Home Based Newborn Care (HBNC)		PNC Visit after Delivery						
		1st Day	3rd Day	7th Day	14th Day	21st Day	28th Day	42nd Day
Date of PNC Visit								
No. of IFA Tabs given to Mother								
Indicate danger sign(s)*	*(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)*							
	Mother							
	(A) Jaundice (B) Diarrhea (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)							
	Infant							
Weight of infant (Kg)								
If danger sing(s) present for mother or Infant, Indicate place & name of referral facility	*(A) PHC (B) CHC (C) District Hosp., (D). Private Hosp./ Other (Specify),*							
	Mother							
	Infant							
Indicate post partum contraception (PPC) method being used	*(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)*							
If died, date and probable cause of death								
Mother death	*(A) Eclampsia (B) Haemorrhage (PPH) (C) Anaemia (D) High Fever (E) Other (Specify)*							
	Cause							
	Date							
Infant death	*(A) Asphyxia (B) Low Birth Weight (C) Fever (D) Diarrhoea (E) Pneumonia (F) Any Other (Specify)*							
	Cause							
	Date							
Place of death (Home/Hospital/ In Transit)								
Remarks (if any)								

Signature of ANM : ☐ Signature of Supervisor : ☐

Data Reporting Format-Child
FY: 2016-17

District: _____ Block: _____ Health Facility: _____

Sub Health Facility: _____ Village: _____

Name of Health Provider (ANM): _____ Name of ASHA : _____

Child - Identification Details:

MCTS ID: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

RCH ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Register S.No.: ☐☐☐

Name of Child: _____ Sex of Child: Male ☐ Female ☐

Mother's Name: _____ Father's Name: _____

Address: _____

Aadhar No.: ☐☐☐☐☐☐☐☐☐☐☐☐

EID No.: ☐☐☐☐ / ☐☐☐☐☐ / ☐☐☐☐☐ Date d d m m y y

Time.: H H : M M : S S

Child - Registration

RCH ID No. of Mother: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of Registration*: d d m m y y

Date of Birth: d d m m y y Weight at Birth (Kg) ☐.☐

Religion: ☐ Hindu ☐ Muslim ☐ Sikh ☐ Christian ☐ Other

Caste : ☐ Other ☐ ST ☐ SC

Mobile Number :

☐ Mother

☐ Father

☐ Other

Place of Birth:

☐ DH ☐ CHC ☐ PHC ☐ Sub-Center ☐ Other Public Facility ☐ Acc. Pvt. Hospital

☐ Other Pvt. Hospital ☐ Home ☐ Sub District Hospital ☐ Medical College Hospital

☐ In Transit Urban Health Center

Note Facility Name

Child - Tracking of Services

Immunization	Given Date	Immunization	Given Date
BCG		OPV Booster	
OPV-1		DPT Booster	
DPT-1		Measles (2nd Dose)	
Hepatitis-B1		Vitamin A (2nd Dose)	
Pentavalent-1*		JE 2	
OPV-2		Received all vaccines required by 2 years of age (Yes/No)	
DPT-2		Vitamin A (3rd Dose)	
Hepatitis-B2		Vitamin A (4th Dose)	
Pentavalent-2*		Vitamin A (5th Dose)	
OPV-3		Vitamin A (6th Dose)	
DPT-3		Vitamin A (7th Dose)	
Hepatitis-B3		Vitamin A (8th Dose)	
Pentavalent-3*		Vitamin A (9th Dose)	
Measles (1st Dose)		DPT Booster-2	
Vitamin A (1st Dose)		Add new vaccine (if any)	
JE (1st Dose)		*Vaccine –1*	
Fully Immunization within 12 months of age (Yes/No)		*Vaccine –1*	
☐ Yes		*Vaccine –1*	

AEFI reported (if any)

☐ NIL

☐ Non-serious

Non-Serious Reason

☐ Serious

☐ Hospitalization

☐ Clustering of Cases

☐ Disability Death

Details of Vaccine -

Name	*Batch*
Exp. Date	*Manufacturer*

Child - Case Close

Reason ☐ - Death ☐ Migrate out (Left)

Death Date & Place

Date of death: d d m m y y

☐ Hospital ☐ Home ☐ Transit

Cause of Death:

☐ Low Birth Weight ☐ Pneumonia

☐ Diarrhoea ☐ Measles ☐ High Fever

☐ Any Other (Specify)

☐ Other (Specify): *Reason*

Remark (If any):

Data Reporting Format-Child
FY: 2016-17

Child - Tracking of Services

Date of Registration*: d d m m y y

Only (Exclusive breastfeeding was given upto 6 months (Yes/No)		☐ Yes ☐ No
Complementary feeding initiated after 6 months (Yes/No)		☐ Yes ☐ No
If No, at what age (in Months) Complementary feeding was initiated		m m
When Child comes for first dose of **Measles** (Between 9-12 Months) take the weight of the child & ask the mother if child had diarrhea and or pneumonia (fever and fast breathing/chest-in-drawing) is last 15 days)	Date of visit	d d m m y y
	Weight of the Child (KG)	Kg
	Diarrhoea (Yes/No)	☐ Yes ☐ No
	If Yes, ORS given (Yes /No)	☐ Yes ☐ No
	Pneumonia (Fever and fast breathing/chest-in drawing (Yes/No))	☐ Yes ☐ No
	If Yes, Antibiotics given (Yes/No/Don't Know)	☐ Yes ☐ No ☐ Don't Know
When Child comes for first booster dose of **DPT,** (Between 16-24 months) take the weight of the child & ask the mother if child had diarrhea and or pneumonia (fever and fast breathing/chest-in-drawing) is last 15 days)	Date of visit	d d m m y y
	Weight of the Child (KG)	Kg
	Diarrhoea (Yes/No)	☐ Yes ☐ No
	If Yes, ORS given (Yes /No)	☐ Yes ☐ No
	Pneumonia (Fever and fast breathing/chest-in drawing (Yes/No))	☐ Yes ☐ No
	If Yes, Antibiotics given (Yes/No/Don't Know)	☐ Yes ☐ No ☐ Don't Know
Remarks (If any):	_____	

Signature of ANM : _____ Signature of Supervisor : _____