GURU GOBIND SINGH MEDICAL COLLEGE, FARIDKOT. (PUNJAB)- 151203.
(Constituent Medical College of Baba Farid University of Health Sciences, Faridkot)
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Phone: 01639-251111 Fax : 01639-251070

No.Purchase/GGS/2017/..1597.. Dated..13/1/17.....

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Sub: Quotation for supply of material required at this Institution.

Sealed quotations are invited for supply of material on terms & Conditions given as under.

Sr.No.	Name of Item	Qty Required
1.	File Folder Multicolor	**As per requirement**
2.	Treatment continuation and Clinical Condition Record Sheet (front and back printing) 2 Color	
3.	Monitoring and Nurses Orders Sheet Front and back Printing	
4.	Admission Sheet (4 pages) 04 Color	
5.	Discharge card (4 pages) 4 color	
6.	Investigation Sheet 2 Color	
7.	Discharge Note	
8.	Referral Note	
9.	Community Follow-up Card	
10.	Admission Register	
11.	Follow Up Register	
12.	OPD Register	
13.	Facility Follow Up Record Book	
14.	Antenatal Steroid use record Register	
15.	Newborn Corner register	

Terms & Conditions:

1. The material should be of Good Quality and according to the requirement as per attached required specifications.
2. The samples of the paper to be used for printing as per required guidelines should be submitted along with the bid.
3. The rates should be submitted on the Letter Head of the Bidder with complete specification of the each item with number of pages of each Pad/register to be supplied.
4. Supply should be **F.O.R** Destination.
5. The material should be supplied within 7 days from the confirmation of the orders.
6. Rates quoted should not be more than those quoted to **DGS&D** and any other Central or State Govts. Organizations.
7. The payment will be made after satisfactory supply of the material.
8. Taxes should be clearly mentioned.

Principal
G.G.S. Medical College
FARIDKOT

Principal, GGSMCH reserves all rights to reject the material/Quotations without assigning any reason.

Note: Only Terms & Conditions mentioned on this Quotation will be considered for supply order.

You are requested to send your lowest bid in sealed envelope, addressed to The PRINCIPAL, G.G.S Medical College, FARIDKOT super scribing "Quotation " for **"Record Material"** on the top of Envelope.

Last Date for receipt of Tender in Principal Office is **18.01.2017** by **2.00 Pm** through **Registered/Speed-Post/Trackable Courier** Only.

Principal

Printing Guidelines for SNCU Record Formats

- Software to operate the CD : Corel Draw Version 15 or Higher
- Copy the Fonts in your Windows Folder
- Color mode : CMYK

Note: - Ensure the printing guidelines are strictly followed.

S.No.	SNCU print specifications	Hue	Size (Inch)	Paper Quality
01	File Folder (Cover)	Multicolor	9.6x12	350 GSM Art Card or equivalent quality
02	Treatment Continuation and Clinical Condition Record Sheet (Front and Back Printing) 1) Treatment Continuation Sheet 2) Clinical Condition Record Sheet	2 Color	8.5x11	70 or 90 GSM Maplitho or equivalent quality
03	Monitoring and Nurses Order Sheet (Front and Back Printing) 1) Monitoring Sheet 2) Nurses Order Sheet	2 Color	8.5x11	70 or 90 GSM Maplitho or equivalent quality
04	Admission Sheet (4 Pages)	4 Color	8.5x11	120 GSM Maplitho or equivalent quality
05	Discharge Card (4 Pages)	4 Color	8.5x11	120 GSM Maplitho or equivalent quality (Perforation at Joint)
06	Investigation Sheet	2 Color	8.5x11	70 or 90 GSM Maplitho or equivalent quality
07	Discharge Note	4 Color	8.5x11	120 GSM Maplitho or equivalent quality (100 Page per perforated booklet)
08	Referral Note	4 Color	8.5x11	120 GSM Maplitho or equivalent quality (100 Page perforated and self carbon booklet)
09	Community Follow-up Card	4 Color	8 X 5.2	270 GSM Ivory Card Sheet or 300 GSM Art Paper
10	**Admission Register**			
	i) Admission Register (Register Cover design print to be pasted on brown board)	4 Color	22x17	70 or 90 GSM Maplitho or equivalent quality
	ii) Admission Register Inner	Single Color	22x17	70 or 90 GSM Maplitho or equivalent quality (150 Page per Register)
11	Follow – up Register	Single Color	14x9	70 or 90 GSM Maplitho or equivalent quality (100 pages per register) Register Cover should be on brown board.
12	OPD Register	Single Color	14x9	70 or 90 GSM Maplitho or equivalent quality (100 pages per register) Register Cover should be on brown board.
13	**Facility Follow-up Record Book**			
	i) Facility Follow-up record Book (Cover)	4 Color	9 X 4.25	350 GSM Art Card or equivalent quality
	ii) Facility Follow-up record Book (Inner)	4 Color	9 X 4.25	70 or 90 GSM Maplitho or equivalent quality (100 pages per Book)
14	Antenatal Steroid use record register	Single Color	14x9	70 or 90 GSM Maplitho or equivalent quality (100 pages per register) Register Cover should be on brown board.
15	Newborn corner register	Single Color	14x9	70 or 90 GSM Maplitho or equivalent quality (100 pages per register) Register Cover should be on brown board.

INVESTIGATION SHEET

SNCU Reg. No..... Date of Admission.....

Baby of (Mother's name)..... Sex.....

Investigation	Date:	Date:	Date:	Date:	Date:
Hb					
PCV					
Total WBC Count					
Differential WBC Count					
Band Form/I.T. Ratio					
Platelet Count					
Peripheral Smear					
PT / PTTK / FDP					
CRP					
Random Blood Glucose					
Blood Urea Nitrogen					
Serum Creatinine					
Serum Calcium					
Serum Sodium					
Serum Potassium					
Serum Bilirubin : Total / Indirect / Direct					
SGPT					
Total Protein/Ser. Albumin					
Urine R&M					
Stool for Occult Blood					
Blood Gas : Arterial / Venous	Date : Time : FIO2 : PH : PCO2: PO2: HCO3: Satn :	Date : Time : FIO2 : PH : PCO2: PO2: HCO3: Satn :	Date : Time : FIO2 : PH : PCO2: PO2: HCO3: Satn :	Date : Time : FIO2 : PH : PCO2: PO2: HCO3: Satn :	Date : Time : FIO2 : PH : PCO2: PO2: HCO3: Satn :
C.S.F.	Date : Cells $<^{P}_{L}$ Sugar : Protein : Culture :			Date : Cells $<^{P}_{L}$ Sugar : Protein : Culture :	
Urine Culture	Date :			Date :	
Blood Culture	Date :			Date :	
X-Ray	Date :			Date :	
USG	Date :			Date :	
CT / MRI	Date :			Date :	
Any Other	Date :			Date :	

This Sheet has to be filled by Nurse on Duty

DISCHARGE NOTES : FOR SNCU RECORD

SNCU Reg. No.			Sex : M / F
Baby of (Mother's Name)			Father's Name :
Date & Time of Discharge	...../...../20.....	Age on Discharge :	Wt. on Discharge (Kg) :
Final Outcome	Successfully Discharged / Left Against Medical Advice / Referred / Expired		

***Final Diagnosis** (⬭ Encircle the most relevant single diagnosis, If multiple causes also mention all relevant numbers in the end as per priority)

- ELBW (999 gm or less) : P 07.0
- Other LBW (1000 gm – 2499 gm) : P 07.1
- Extreme Immaturity (<28 Weeks) : P 07.2
- Prematurity (28-<37 Weeks) : P 07.3
- Small for Gestational Age (IUGR) : P 05.1
- Neonatal Aspiration of Meconium : P 24.0
- RDS of Newborn (HMD) : P 22.0
- Transient Tachypnoea of Newborn : P 22.1
- Pneumothorax : P 25.1
- Congenital Pneumonia : P 23
- Acquired Pneumonia : J 15
- Primary Sleep Apnoea of Newborn : P 28.3
- Birth Asphyxia : P 21.0
- HIE of Newborn : P 91.6
- Neonatal Sepsis : P 36.9
- Meningitis : G 00
- Convulsions of Newborn : P 90 (Hypoxic, Hypoglycaemic, Hypocalcaemic, CNS Infections, Birth Trauma, Metabolic, Other, Unknown Cause)
- Hemolytic disease of Newborn : P 55
- Neonatal Jaundice : P 59
- Acute Renal Failure : N 17
- Neonatal Cardiac Failure : P 29.0
- Shock : R 57
- DIC : P 60
- Intraventricular Hemorrhage : P 52.3
- Neonatal Diarrhoea : A 09
- Tetanus Neonatorum : A 33
- Hypothermia of Newborn : P 80
- Environmental Hyperthermia of Newborn : P 81.0
- Neonatal Hypoglycaemia : P 70.4

*(Based on WHO, ICD - 10 Version: 2010)

- Congenital Malformation :
  - (a) Cong. Diaphragmatic Hernia : Q 79.0
  - (b) Cong. Hydrocephalus : Q 03
  - (c) Meningomyelocele : Q 05
  - (d) Imperforate anus : Q 42.3
  - (e) T.O. Fistula : Q 39.2
  - (f) Congenital Heart Disease : Q 21
  - (g) Cleft Palate : Q 35
  - (h) Cleft Lip : Q 36
  - (I) Cleft Palate with Cleft Lip : Q 37
  - (j) Congenital Deformities of Hip : Q 65
  - (k) Congenital Deformities of Feet : Q 66
  - (l) Other Malformation (.....)
- Any Other Diagnosis (.....)
- **Multiple Diagnosis**-Mention All Relevant Codes :

a ..... b ..... c ..... d .....

TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Step-Down : Yes / No (If yes duration.....)
4. KMC : Yes / No (If yes duration.....)
5. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)	.....	.....
b)	.....	.....
c)	.....	.....
d)	.....	.....

- .....
- .....
- .....
- .....
- .....

COURSE DURING TREATMENT

CONDITION ON DISCHARGE

IMMUNIZATION STATUS

- RI Card ☐
- BCG ☐
- OPV (0 Dose) ☐
- Hepatitis B (Birth Dose) ☐

TREATMENT ADVISED ON DISCHARGE

- .....
- .....
- .....

Doctor's Name and Signature

This Sheet has to be filled on Discharge by Doctor on Duty

SPECIAL NEW BORN CARE UNIT

Guru Gobind Singh Hospital Faridkot, Punjab

DISCHARGE CARD

(Developed by UNICEF for NHM)

SNCU Reg. No.....

Doctor In charge.....

MCTS No.

Baby of (Mother's Name)			Sex:
Father's Name			Category:
Complete Address with Village Name / Ward No.			Date of Birth:
Contact No. & Relation	1.	2.	
Date and Time of Admission		Age on Admission :	Wt. on Admission (Kg) :
Date and Time of Discharge		Age on Discharge :	Wt. on Discharge (Kg) :
Place of Delivery		Type of Admission :	
Indication for Admission			
Final Diagnosis			
Final Outcome			

PRESENTING COMPLAINTS :

MOTHER'S INFORMATION : Past History and ANC Period

(Put Same as in Case Record Sheet)

Mother's Age :_____Yrs. Mother's Wt. :_____Kgs. Age at Marriage :_____Yrs. Consanguinity :_____

Birth Spacing :_____ L.M.P. :_____ E.D.D.:_____ Antenatal Visit's :_____

T.T. Doses :_____ Gestation Weeks :_____ Gravida :_____ Para :_____

Live Birth :_____ Abortion :_____ Hb :_____ Blood Group :_____

PIH :_____ Drug:_____ Radiation :_____ Illness :_____

APH :_____ GDM _____ Thyroid :_____ VDRL :_____

HbsAg :_____ HIV Testing :_____ Amniotic Fluid Volume :_____

Any Other Significant History :

This Card has to be filled on Discharge by Doctor on Duty

MOTHER'S INFORMATION : During Labour

(Put Same as in Case Record Sheet)

Antenatal Steroids :_____ Number of Doses :_____ Time Between Last Dose & Delivery :_____

Foul Smelling Discharge :_____ Uterine Tenderness :_____ Leaking P.V. > 24 Hours :_____

H/O Fever :_____ PPH :_____ PIH :_____

Amniotic Fluid :_____ Presentation :_____ Labor :_____

Course of Labor :_____ E/O Feotal Distress:_____ Type of Delivery :_____

Indication for Caesarean, if Applicable [_____] Delivery Attended by :_____

BABY'S INFORMATION : At Birth

(Put Same as in Case Record Sheet)

Cried Immed. after Birth :_____ Wt. at Birth :_____Kgs. Gestational Age_____(in completed weeks)

Maturity :_____ APGAR at 1 Min :_____ APGAR at 5 Min :_____

Resuscitation Required :_____ Vitamin K Given :_____ Breast Fed within 1 Hour :_____

BABY'S INFORMATION : On Admission

(Put Same as in Case Record Sheet)

GENERAL EXAMINATION

General Condition :_____ Temperature :_____°C Heart Rate :_____/min Apnea:_____ RR :_____/min

B.P. :_____ Grunting :_____ Chest Indrawing :_____ Head Circumference :_____c.m.

Length :_____c.m. Color :_____ Cry :_____ CRT > 3 secs :_____

Skin pinch > 2 secs :_____ Meconium Stained Cord :_____ Tone :_____ Convulsions :_____

Jaundice :_____ Bleeding :_____ Bulging Anterior Fontanel :_____ Taking Breast Feed :_____

Sucking :_____ Attachment :_____ Umbilicus :_____ Skin Pustules :_____

Congenital Malformation :_____ Blood Sugar :_____ Oxygen Saturation :_____

SYSTEMIC EXAMINATION

CVS : .....

RESPIRATORY : .....

PER ABDOMEN : .....

CNS : .....

OTHER SIGNIFICANT FINDING : .....

This Card has to be filled on Discharge by Doctor on Duty

TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Step-Down : Yes / No (If yes duration.....)
4. KMC : Yes / No (If yes duration.....)
5. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)	.....	.....
b)	.....	.....
c)	.....	.....
d)	.....	.....

- .....
- .....
- .....
- .....
- .....

COURSE DURING TREATMENT

RELEVANT INVESTIGATIONS

CONDITION ON DISCHARGE

IMMUNIZATION STATUS

RI Card ☐ BCG ☐ OPV (0 Dose) ☐ Hepatitis B (Birth Dose) ☐

TREATMENT ADVISED ON DISCHARGE

1. Exclusive Breast Feeding till 6 months of Age.
2. Burp well after feed.
3. Maintain Temperature.
4. Immunization as per Schedule.
5. Follow-up as per Schedule.

- .....
- .....
- .....
- .....
- .....

Doctor's Name and Signature

This Card has to be filled on Discharge by Doctor on Duty

Institutional Follow up at S.N.C.U.

Visit	Anthropometry	Immunization Status	Examination Findings	Advice
8 Days Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Systemic :	Seen by.....
1 Month Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic :	Seen by.....
3 Months Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
6 Months Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....
1 Year Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.) ..... M.U.A.C. (mm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....

This part has to be filled on follow-up by Doctor on Duty

REFERRAL SUMMARY

SNCU District Hospital.....

Baby of (Mother's Name)		Father's Name :		
SNCU Reg. No.		Sex : M / F	Age :	Weight (Kg) :
Date & Time of Referral	...../...../20.....	Place of Referral :		
Indication for Referral	Ventilation / Surgical Intervention / Diagnostic Work up / Metabolic Work up / Dialysis / Other			

***Final Diagnosis** (Encircle the most relevant single diagnosis. If multiple causes also mention all relevant numbers in the end as per priority)

- ELBW (999 gm or less) : P 07.0
- Other LBW (1000 gm – 2499 gm) : P 07.1
- Extreme Immaturity (<28 Weeks) : P 07.2
- Prematurity (28-<37 Weeks) : P 07.3
- Small for Gestational Age (IUGR) : P 05.1
- Neonatal Aspiration of Meconium : P 24.0
- RDS of Newborn (HMD) : P 22.0
- Transient Tachypnoea of Newborn : P 22.1
- Pneumothorax : P 25.1
- Congenital Pneumonia : P 23
- Acquired Pneumonia : J 15
- Primary Sleep Apnoea of Newborn : P 28.3
- Birth Asphyxia : P 21.0
- HIE of Newborn : P 91.6
- Neonatal Sepsis : P 36.9
- Meningitis : G 00
- Convulsions of Newborn : P 90 (Hypoxic, Hypoglycaemic, Hypocalcaemic, CNS Infections, Birth Trauma, Metabolic, Other, Unknown Cause)
- Hemolytic disease of Newborn : P 55
- Neonatal Jaundice : P 59
- Acute Renal Failure : N 17
- Neonatal Cardiac Failure : P 29.0
- Shock : R 57
- DIC : P 60
- Intraventricular Hemorrhage : P 52.3
- Neonatal Diarrhoea : A 09
- Tetanus Neonatorum : A 33
- Hypothermia of Newborn : P 80
- Environmental Hyperthermia of Newborn : P 81.0
- Neonatal Hypoglycaemia : P 70.4

*(Based on WHO, ICD - 10 Version: 2010)

- Congenital Malformation :
  (a) Cong. Diaphragmatic Hernia : Q 79.0
  (b) Cong. Hydrocephalus : Q 03
  (c) Meningomyelocele : Q 05
  (d) Imperforate anus : Q 42.3
  (e) T.O. Fistula : Q 39.2
  (f) Congenital Heart Disease : Q 21
  (g) Cleft Palate : Q 35
  (h) Cleft Lip : Q 36
  (I) Cleft Palate with Cleft Lip : Q 37
  (j) Congenital Deformities of Hip : Q 65
  (k) Congenital Deformities of Feet : Q 66
  (l) Other Malformation (.....)
- Any Other Diagnosis (.....)
- **Multiple Diagnosis**-Mention All Relevant Codes : a ..... b ..... c ..... d .....

TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)	.....	.....
b)	.....	.....
c)	.....	.....
d)	.....	.....

- .....
- .....
- .....
- .....
- .....

PRESENTING COMPLAINTS & COURSE DURING TREATMENT

RELEVANT INVESTIGATIONS

CONDITION AT TIME OF REFERRAL

TREATMENT ADVISED ON WAY

1. Keep Baby Warm.
2. Take Care of Airway and Breathing.
3. Monitor Color / Heart Rate / Blood Glucose.

- .....
- .....
- .....

Doctor's Name and Signature

This Sheet has to be filled on Referral by Doctor on Duty

SPECIAL NEW BORN CARE UNIT

GURU GOBIND SINGH HOSPITAL FARIDKOT, PUNJAB
Developed by UNICEF for NHM

Admission Register

Sister Incharge.....

Start Date..... End Date.....

Special New Born Care Unit, Guru Gobind Singh Hospital Faridkot, Punjab

Month.................Year.............

To be Filled at the Time of Admission by Sister on Duty																			To be Filled at the Time of Discharge by Sister on Duty				
Admission Date (DD/MM/YY) / Admission Time	Hospital IPD NO.	SNCU Reg. No.	Baby of : (Mother's Name)	Father's Name	Sex	Age	Wt. on Admission.	Caste	Complete Address	Contact No. (Relative / Parent)	Name of ASHA / AWW	Contact No.	Place of Delivery with Name	Type of Admission	Maturity	Indication for Admission	Provisional Diagnosis	Name and Sign. Of Person Entering Details	Final Diagnosis	Out Come	Date of DISCHARGE / LAMA / REFERRAL / DEATH	Time of DISCHARGE / LAMA / REFERRAL / DEATH	Doctor Incharge
		District/Year/ Monthly S.No./ Yearly S.No.			Male Female	In Days	In Kgs	GEN/OBC/SC/ST	MENTION FULL ADDRESS WITH BLOCK NAME / SHC / VILLAGE (MENTION WARD NO. FOR URBAN AREA)				Ambulance/ Home / (Pvt. Hospital / Govt. Hospital) Name	1. INBORN 2. OUTBORN (Hospital Referred) 3. OUTBORN (Community Referred)	PRETERM (<37 Wks)/ FULLTERM (37- <42 Wks)/ POSTTERM (=>42 Wks)	PICK UP FROM CASE SHEET	PICK UP FROM CASE SHEET		PICK UP FROM CASE SHEET	DISCHARGE / LAMA / REFERRAL / DEATH	DD/MM/YY		

TREATMENT CONTINUATION SHEET

SNCU Reg. No..... Date of Admission.....

Baby of (Mother's name)..... Sex.....

Birth Weight ..... Doctor Incharge .....

	Date..... Wt..... PND.....	Date..... Wt..... PND.....
Oxygen and Other Supportive Care		
I / V Drugs		
I / V Fluids		
Oral Drugs and Feeding		
Investigations Advised		
Planning for Next Day		

This Sheet has to be filled by Doctor Incharge of Patient

PTO

CLINICAL CONDITION RECORD

Clinical Findings on Round and Advise	Date..... Wt..... PND.....	Date..... Wt..... PND.....
Morning Round Doctor's Name _____ _____ Time _____ Signature _____		
Evening Round Doctor's Name _____ _____ Time _____ Signature _____		
Night Round Doctor's Name _____ _____ Time _____ Signature _____		

This Sheet has to be filled by Doctor on Duty

MONITORING SHEET

SNCU Reg. No..... Date of Admission.....

Baby of (Mother's name)..... Sex.....

Weight..... Date.....

Time																							
Activity (Dull / Active)																							
Temperature																							
Colour																							
HR / RR																							
CRT / B.P.																							
O_2 Flow Rate / FIO_2																							
Oxygen Saturation																							
Blood Glucose																							
Urine																							
Stool																							
Abdominal Girth																							
R.T. Aspirate																							
IV Patency (Yes / No)																							
Blood Collection																							
Other																							

This Sheet has to be filled by Nurse on Duty

NURSES ORDER SHEET

Treatment Administered	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Total (ml)
Oral Feeds Feeding Tube (ml) Spoon & Cup (ml) Breast Feed (adlib)													
Oral Drugs 1. ..... 2.													
IV Drugs (Also Record Fluid Volume) 1. ..... 2. ..... 3.													
IV Fluids													
1. ..... (Enter Rate & fluid given between each time slot)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	
2. ..... (Enter Rate & fluid given between each time slot)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	
IV Infusions													
1. ..... (Enter Rate & fluid given between each time slot)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	
2. ..... (Enter Rate & fluid given between each time slot)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	.....ml / hr (.....ml)	
IV Bolus .....ml													
Blood / Packed Cell / FFP / Platelet (.....ml) Rate..... ml / hr													
Any Other Treatment													
.....													
												Total Input in 24 Hours (ml)	.....

SPECIAL NEW BORN CARE UNIT

Guru Gobind Singh Hospital Faridkot, Punjab

NEONATAL CASE RECORD SHEET

(Developed by UNICEF for NHM)

SNCU Reg. No.....

Doctor In charge..... MCTS No.

Baby of (Mother's Name)			Sex: Male / Female / Ambiguous
Father's Name			Category: General / OBC / SC / ST
Complete Address with Village Name / Ward No.			
Contact No. & Relation	1.	2.	
Date and Time of Birth	...../...../20.....	Birth Weight (Kg) :	
Date and Time of Admission	...../...../20.....	Age on Admission :	Wt. on Admission (Kg) :
Date and Time of Discharge	...../...../20.....	Age on Discharge :	Wt. on Discharge (Kg) :
Type of Admission	Inborn / Out born (Health Facility Referred) / Out born (Community Referred)		
Place of Delivery	Home / Ambulance/ Pvt. Hospital / Govt. Hospital (Name) :		
Referred From		Mode of Transport : Self Arranged / Govt. Provided	

Indication for Admission (⬭ Encircle the most relevant single indication. If multiple indication also mention all relevant numbers in the end as per priority)

1. Prematurity <34 weeks
2. Low Birth Weight <1800 gm.
3. Perinatal Asphyxia
4. Neonatal Jaundice
5. Resp. Distress (Rate>60 or Grunt / Retractions)
6. Large Baby (>4 Kg. at 40 weeks)
7. Refusal to Feed
8. Central Cyanosis
9. Apnea / Gasping
10. Neonatal Convulsions
11. Baby of Diabetic mother
12. Oliguria
13. Abdominal Distension
14. Hypothermia <35.4 °C
15. Hyperthermia >37.5 °C
16. Hypoglycemia <45 mg%
17. Shock : Cold Periphery with CFT >3 sec & Weak Fast Pulse
18. Meconium Aspiration
19. Bleeding
20. Diarrhoea
21. Major Congenital Malformation
22. Unconsciousness
23. Any Other (.....)
24. **Multiple Indication** - Mention All Relevant Numbers: a ..... b ..... c ..... d .....

Provisional Diagnosis:

***Final Diagnosis** (⬭ Encircle the most relevant single diagnosis. If multiple causes also mention all relevant numbers in the end as per sequence)

- ELBW (999 gm or less) : P 07.0
- Other LBW (1000 gm – 2499 gm) : P 07.1
- Extreme Immaturity (<28 Weeks) : P 07.2
- Prematurity (28-<37 Weeks) : P 07.3
- Small for Gestational Age (IUGR) : P 05.1
- Neonatal Aspiration of Meconium : P 24.0
- RDS of Newborn (HMD) : P 22.0
- Transient Tachypnoea of Newborn : P 22.1
- Pneumothorax : P 25.1
- Congenital Pneumonia : P 23
- Acquired Pneumonia : J 15
- Primary Sleep Apnoea of Newborn : P 28.3
- Birth Asphyxia : P 21.0
- HIE of Newborn : P 91.6
- Neonatal Sepsis : P 36.9
- Meningitis : G 00
- Convulsions of Newborn : P 90 (Hypoxic, Hypoglycaemic, Hypocalcaemic, CNS Infections, Birth Trauma, Metabolic, Other, Unknown Cause)
- Hemolytic disease of Newborn : P 55
- Neonatal Jaundice : P 59
- Acute Renal Failure : N 17
- Neonatal Cardiac Failure : P 29.0
- Shock : R 57
- DIC : P 60
- Intraventricular Hemorrhage : P 52.3
- Neonatal Diarrhoea : A 09
- Tetanus Neonatorum : A 33
- Hypothermia of Newborn : P 80
- Environmental Hyperthermia of Newborn : P 81.0
- Neonatal Hypoglycaemia : P 70.4
- Congenital Malformation :
  (a) Cong. Diaphragmatic Hernia : Q 79.0
  (b) Cong. Hydrocephalus : Q 03
  (c) Meningomyelocele : Q 05
  (d) Imperforate anus : Q 42.3
  (e) T.O. Fistula : Q 39.2
  (f) Congenital Heart Disease : Q 21
  (g) Cleft Palate : Q 35
  (h) Cleft Lip : Q 36
  (I) Cleft Palate with Cleft Lip : Q 37
  (j) Congenital Deformities of Hip : Q 65
  (k) Congenital Deformities of Feet : Q 66
  (l) Other Malformation (.....)
- Any Other Diagnosis (.....)
- **Multiple Diagnosis**-Mention All Relevant Codes : a ..... b ..... c ..... d .....

*(Based on WHO, ICD - 10 Version: 2010)

This Sheet has to be filled on Admission by Doctor on Duty

MOTHER'S INFORMATION : Past History and ANC Period

Mother's Age ..... Yrs. Mother's Wt .....Kgs. Age at Marriage.....Yrs.

Consanguinity : Yes [ ] No [ ] Birth Spacing: < 1 Yr / 1-2 Yr / >2-3 Yr / > 3 Yr / Not Applicable

Gravida :..... Para :..... Live Birth :..... Abortion: .....

LMP : ...../...../..... EDD : ...../...../..... Gestation Weeks .....

Antenatal Visit's : None / 1 / 2 / 3 / 4 T.T. Doses : None / 1 / 2

Hb : ..... Blood Group : .....

PIH : No [ ] Yes [Hypertension / Pre Eclampsia / Eclampsia]

Drug : No [ ] Yes [ ] (.....) Radiation : Yes [ ] No [ ]

Illness : Malaria / T.B. / Jaundice / Rash with Fever / U.T.I. / Syphilis/ Other (.....)

APH : Yes [ ] No [ ] GDM : Yes [ ] No [ ]

Thyroid : Euthyroid (N) / Hypothyroid / Hyperthyroid / Not Known

VDRL : Not Done / + Ve / -Ve HbsAg : Not Done / + Ve / -Ve

HIV Testing : Done / Not Done Amniotic Fluid Volume : Adequate / Polyhydraminos / Oligohyd.

Other Significant Information :

MOTHER'S INFORMATION : During Labour

Antenatal Steroids : Yes [ ] No [ ] If Yes, Betamethasone [ ] / Dexamethasone [ ]

No. of doses : [1] [2] [3] [4] Time Between Last Dose & Delivery ..... hrs./ ..... Days

H/O Fever : In 1st Trimester / In 2nd Trimester / In 3rd Trimester / During Labor only if >100.4F

Foul Smelling Discharge : Yes [ ] No [ ] Uterine Tenderness: Yes [ ] No [ ]

Leaking P.V. > 24 Hours. : Yes [ ] No [ ] PIH : Hypertension / Pre Eclampsia / Eclampsia

PPH : Yes [ ] No [ ]

Amniotic Fluid : Clear / Blood Stained / Meconium Stained / Foul Smelling

Presentation . Vertex / Breech / Transverse Labour : Spontaneous / Induced

Course of Labour : Uneventful / Prolonged 1st stage / Prolonged 2nd stage / Obstructed

E/O Feotal Distress : Yes [ ] No [ ] Type of Delivery : LSCS / AVD / NVD

Indication for Caesarean, if Applicable : [Cephalo Pelvic Disproportion] [Malpresentation] [Placenta Previa] [Obstructed Labor] [Foetal Distress] [Prolonged Labour] [Cord Prolapse] [Failed Induction (D[illegible]cia)] [Previous LSCS] [Other .....]

Delivery Attended by : [Doctor] [Nurse] [ANM] [Dai] [Relative] [Any Other].....

Other Significant Information :

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No [ ]"

BABY'S INFORMATION: At Birth

Cried Immed. after Birth	: Yes [ ] No [ ]	Wt. at Birth: ..... Kgs.
Gestational age	: ..... in completed weeks	Maturity : Preterm (<37 Wk) / Full term / Post term (≥42 Wk)
APGAR at 1 Min	: ..... / Not Available	APGAR at 5 Min : ..... / Not Available
Resuscitation Required	: NO [ ] Yes [ ] Tactile Stimulation /Only Oxygen / Bag & Mask [Duration.....min.]/ Intubation / Chest Compression / Adrenaline	
Vitamin K Given	: Yes [ ] No [ ]	Breast Fed within 1 Hour : Yes [ ] No [ ]

BABY'S INFORMATION : On Admission

PRESENTING COMPLAINTS:

GENERAL EXAMINATION

General Condition	: [Alert] [Lethargic] [Comatose]	Temperature .....°C Heart Rate...../min
Apnea	: Yes [ ] No [ ]	RR ...../min. B.P :.....
Grunting	: Yes [ ] No [ ]	Chest Indrawing : Yes [ ] No [ ]
Head Circumference	: .....c.m.	Length .....c.m.
Color	: Pink / Pale / Central Cyanosis / Peripheral Cyanosis	
CRT >3 secs	: Yes [ ] No [ ]	Skin pinch > 2 secs : Yes [ ] No [ ]
Meconium Stained Cord	: Yes [ ] No [ ]	Cry : Absent / Feeble / Normal / High Pitch
Tone	: Limp / Active / Increase Tone	Convulsions : Present on Admission / Past History / No
Jaundice	: Yes [ ] No [ ] If Yes, extent [Face] [Chest] [Abdomen] [Legs] [Palms / Soles]	
Bleeding	: Yes [ ] No [ ] If Yes ,specify site [Skin] [Mouth] [Rectal] [Umbilicus]	
Bulging Anterior Fontanel	: Yes [ ] No [ ]	Taking Breast Feeds : Yes [ ] No [ ]
Sucking	: [Good] [Poor] [No Sucking]	Attachment : [Well attached] [Poorly attached] [Not attached]
Umbilicus	: [Red] [Discharge] [Normal]	Skin Pustules : [No] [Yes <10] [Yes >=10] [Abscess]
Congenital Malformation	: No [ ] Yes [ ] Diaphragmatic Hernia / Hydrocephalus / M.M.C. / Imperforate Anus / T.O. Fistula / Cong. Heart Disease / Cleft Palate / Cleft Lip / Cleft Palate with Cleft Lip / Cong. Deformity of Hip / Cong. Deformity of Feet / Other.....	
Blood Sugar	:	Oxygen Saturation :.....
Other Significant Information	:	

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No [ ]"

SYSTEMIC EXAMINATION

CVS : .....

RESPIRATORY : .....

PER ABDOMEN : .....

CNS : .....

OTHER SIGNIFICANT FINDING : .....

TREATMENT ADVISED : On Admission

INVESTIGATIONS ADVISED : On Admission

Doctor's Name and Signature

सहमति पत्र

हमें डॉक्टर द्वारा बता दिया गया है कि हमारा शिशु गभीर रूप से बीमार है एवं उपचार के दौरान होने वाली जटिलताओं से हमें अवगत करा दिया गया है तथा हमें पूर्ण रूप से विदित है कि उपचार के दौरान समस्याऐं उत्पन्न हो सकती हैं। इन सभी खतरों से अवगत होने के बाद भी हम हमारे बच्चे को एस.एन.सी.यू. जिला चिकित्सालय में उपचार हेतु भर्ती कराने के लिये सहमत हैं।

Foot Print of Newborn
(Left Foot)

अभिभावक के हस्ताक्षर

FINAL OUTCOME

Successfully Discharged / Left Against Medical Advice / Referred / Expired

In Case of Death : Mention Cause of Death (✓ The Most Relevant Single Indication)

1. Respiratory Distress Syndrome
2. Meconium Aspiration Syndrome
3. HIE / Moderate-Severe Birth Asphyxia
4. Sepsis
5. Pneumonia
6. Meningitis
7. Major Congenital Malformation
8. E.L.B.W. (Wt. less than 1000g)
9. Prematurity (<28 weeks of Gestation)
10. Neonatal Tetanus
11. Cause not established
12. Any Other : .....
.....
.....

This Sheet has to be filled on Admission by Doctor on Duty

Sick New Born Care Unit, ...

Date: _____

Facility Follow-up Register

S.No.	SNCU Reg. No.	Name of Child / Mother	Sex	Age	Father's Name	Current Address	Contact No.	Scheduled Follow-up (✓ As Applicable)				
								8 Days	1 Month	3 Months	6 Months	1 Year

This has to be Filled by Nurse in Follow-up OPD

Name of Doctor: _____

Signature: _____

SPECIAL NEW BORN CARE UNIT

GURU GOBIND SINGH HOSPITAL FARIDKOT, PUNJAB

Developed by UNICEF for NHM

Facility Follow-up Record Book

Start Date..... End Date.....

Institutional Follow up at S.N.C.U.

SNCU Reg. No. ..... **Name of Child / Mother** .....

Visit	Anthropometry	Immunization Status	Examination Findings	Advice
Scheduled Date ...../...../20..... Date of Visit ...../...../20.....	Wt. (kg.) ..... Total Length (cm.) ..... Head Circumfer. (cm.)		General : Vision : Hearing : Systemic : Neurodevelopmental :	Seen by.....

Place Carbon Here

This has to be filled on follow-up by Doctor on Duty

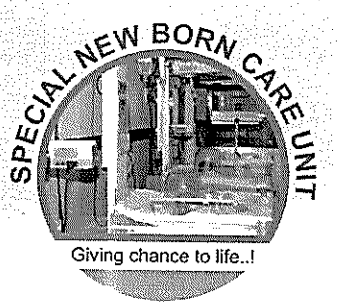
Sick New Born Care Unit, ...

Date: _____

OPD Register

S.No.	OPD No.	Name of Child / Mother	Sex	Age	Current Address	Contact No.	Presenting Complaints	Treatment Advised	Seen By (Name & Signature)

This has to be Filled by Doctor Examining the Patient



GURU GOBIND SINGH HOSPITAL FARIDKOT, PUNJAB
Developed by UNICEF for NHM

New Born Care Corner Register

Sister Incharge.....

Start Date..... End Date.....

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New Born Care Corner Register

Date .....

S.No.	IPD No.	Mothers Name	Time of Birth (am/pm)	Sex	Weight in kg	Apgar at1min /5 min	Maturity (In weeks)	Resuscitation Required (Y/N) If yes give details (Tactile stimulation/ O2/Bag & Mask/Chest compression/ Drugs) including duration	Vitamin K given (Yes/ No)	Congenital Malformation (Yes / No) If yes give details	Any significant risk factor or abnormal examination findings	Routine Advise (Breast Feeding/ cord care/Keep Baby warm)	Special Advise / treatment (If Any) In case of SNCU transfer give reason	Seen By (Name, designation and signature)

Note: This register should be kept in Labor room and filled with in 30 minutes of delivery by Nurse receiving the baby and SNCU doctor on duty who has to compulsorily examine the baby.

टीकाकरण का विस्तृत ब्यौरा

टीके का नाम	कब देना है
बी.सी.जी.	जन्म के समय/ 1 साल की उम्र के भीतर
हेपेटाइटिस बी	जन्म के समय/ जन्म से 24 घंटे के भीतर
ओपीवी– 0	जन्म के समय/ जन्म से 15 दिन के भीतर
ओपीवी– 1,2,3	1½ माह, 2½ माह, 3½ माह की उम्र पर
पेंटावेलेंट– 1,2,3	1½ माह, 2½ माह, 3½ माह की उम्र पर
आई.पी.वी.	3½ माह की उम्र पर
मीजल्स/एम.आर–1,2	9–12 माह की उम्र पर, 16–24 माह की उम्र पर
विटामिन ए– 1,2	9–12 माह की उम्र पर, 16–24 माह की उम्र पर
डीपीटी बूस्टर	16–24 माह की उम्र पर
ओपीवी बूस्टर	16–24 माह की उम्र पर
विटामिन ए– 3 से 9 डोज	तीसरी डोज 24 वें माह पर इसके बाद हर 6 माह में 5 साल की उम्र तक
डीपीटी बूस्टर	5–6 साल की उम्र में
टी.टी.	10–16 साल की उम्र में

_V_A_lll {bE gba

- जन्म के तुरत बाद से ही माँ का दूध पिलाना शुरू करें। (अधिकतम एक घंटे के अन्दर)
- छः माह तक माँ के दूध के अतिरिक्त कुछ भी न दें, पानी भी नहीं।
- बच्चे को स्तनपान के बाद कंधे पर रखकर उसकी पीठ हल्के हाथों से थपथपायें।
- बच्चे के शरीर को हमेशा गर्म रखें, बच्चे को माँ की छाती से सटा कर रखें।
- समय पर सभी टीकाकरण करवायें।
- बच्चे की नाभि में कुछ भी न लगायें एवं कान में तेल न डालें।
- शिशु के छः महीने का होने पर इसे खाना खिलाना शुरू करें। माँ के दूध के अलावा उसे दिन में 3–5 बार खाना खिलायें।
- शिशु का स्वास्थ्य परीक्षण नियमित रूप से ग्राम की आशा/आँगनबाड़ी के द्वारा करायें।
- एस.एन.सी.यू. से छुट्टी होने के उपरांत हरे कार्ड में दर्शायी गई दिनांक पर अपने बच्चे की एस.एन.सी.यू. में पुनः जाँच सुनिश्चित करें।

आपातकालीन स्थिति में कृपया निम्नलिखित पते पर सम्पर्क करें

Ijle'k gesj uotkr f'k'kxqu fpfdRlk bdkbZ

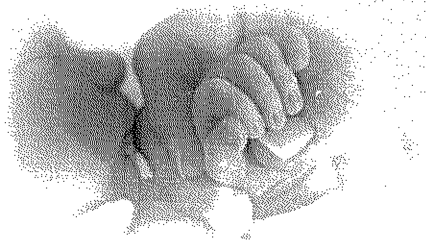
______ - ________

bej tsalh ifjogu gsq

______ - ________

SPECIAL NEW BORN CARE UNIT

Guru Gobind Singh Hospital Faridkot, Punjab



SNCU Reg.No:.................... Date of Birth:....................

Baby of (Mother's Name):.................... Sex:........

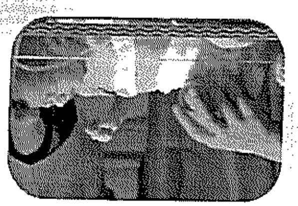
Father's Name:....................

Address:....................

.... Ph. ....

Developed by UNICEF for NHM

2014 VERSION - UNICEF - GOI



खतरे के आम चिन्ह

- स्तनपान या दूध पीने में कमी।
- ज्यादा बीमार हो जाये अथवा सुस्त लगता हो।
- बुखार हो या शिशु ठंडा लगता हो।
- साँस तेज चल रही हो या साँस लेने में कठिनाई हो।
- शिशु नीला पड रहा हो/झटके आ रहे हो।