BNS-043
Public Health and Primary Health Care Skills

LOG BOOK
CERTIFICATE IN COMMUNITY HEALTH FOR NURSES (BPCCHN)

LOG BOOK

Student Name ______________________________________

Enrolment No. ________________________________________

PSC: Address ________________________________________

PSC Code _____________________________________________
INTRODUCTION

Having gone through the practical course on Public Health and Primary Health Care Skills (BNSL 043) you must have understood as to what activities you will have to practice at the Programme Study Centre during the Practical Contact Programme. The practical experience for the programme has been planned for 50 days (300 hours) for carrying out the practical activities you will be posted in Programme Study Centre/ District Hospital for 22 days, Community Health Centre (CHC) for 10 days Primary Health Centre (PHC) for 10 days Sub Centre (SC) for 6 days and Urban Primary Health Centre (UHC) for 2 days. Programme Incharge will plan and inform you the schedule of activities and the areas of activities in various health facilities. The Academic Counselors will demonstrate and guide you to practice all the activities/ skills, thereafter you will have to practice the activities as per the guidelines given in the log book. You have to make record of day to day activities in your log book and get it signed. Before each activity you must refer the practical manual.

The Performa and guidelines which you will use for doing practical activities and performing the skills have been included in the logbook. You will have to fill these Performa wherever required. Wherever there are no Performa you may record the activity in the blank sheet. In case some additional findings are noted you may attach additional sheets for recording.

We hope you will get good practical learning experience while working through this log book.

Kindly read the instructions given in the log book
<table>
<thead>
<tr>
<th>Activity 1</th>
<th>Community Assessment and Identification of Common Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity 2</td>
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<td>Assessment and Management of STIs/RTIs</td>
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<td>Activity 34</td>
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<td>Activity 35</td>
<td>Management of abortion and counseling</td>
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<td>Activity 41</td>
<td>Promoting and Monitoring Growth and Development and Plotting Chart</td>
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</tbody>
</table>
Activity 42 | Immunization and safe injection practices
Activity 43 | Use of Equipments

### 1.0 GENERAL INSTRUCTIONS TO STUDENTS

This log book is a compulsory component of the Practical Course BNSL-043 of Certificate in Community Health for Nurses (BPCCHN). You are required to maintain a record of all the learning activities that you perform as a part of this course. This log-book contains different types of activities. We have provided guidelines and case record proforma/formats for all the activities. You are required to fill up the case record proforma at PSC/CHC/PHC/SC and UHC respectively.

### 1.1 OBJECTIVES OF THE LOG BOOK

The objectives of the log-book are as follows:

- enable the counselors to have a first hand information about the activities performed by you:
- assess the clinical/academic experience gained by you:
- help you in planning your activities in advance so that you can complete them within the time frame; and
- document your practical experience towards the practical component of BPCCHN.

### 1.2 HOW TO USE THE LOG-BOOK?

You should refer to the table mentioning the minimum number of cases/patients to be seen by you for every activity/skill at various health facilities. We expect you to fill up case records formats at PSC/CHC/PHC/SC and UHC as mentioned under each activity.

- Read all the blocks of the practical course, BNSL-043 thoroughly.
- Go through the list of activities given in the initial pages of your logbook.
- Read all the guidelines given under each activity.
- General guidelines are given in the initial pages of the logbook to get acquainted with the activities to be performed.
- Record the activities in the proforma given in the logbook.
- Attach additional sheet if required

### 1.3 PERFORMING THE ACTIVITIES

During your practical experience you will be posted for a period of total 50 days (300 hours) in various health facility such as DH, CHC, PHC, SC and UHC as per schedule (Refer Appendix-1).

During your posting in PSC/DH you will be demonstrated all the listed activities in concerned outpatient/inpatient departments / clinics/ community/ family/ sub-centre etc by the counsellor.

Thereafter cases will be allotted to you in the outpatient/inpatient departments / clinics/ community/ family/ subcentre for achieving proficiency. You may also make presentation of cases as and when required. These case taking and presentation will be distributed across various health facilities.
You should practice at least 2 cases in PSC/DH, 5 cases in CHCs, 3 cases in PHC and 2 cases in SC. You need to record at least two cases in the log-book during posting at various health facilities. For the other cases, you should fill up only the blank logbook pages for specific activity as per given.

One case will also be evaluated by the counsellor of CHC. The details of the rest of the cases which you will see during posting (not recorded) are to be filled in as one-line statement in the log page provided for this purpose and get all these signed by counselor.

Please ensure that whenever a case is seen by you at PSC/DH or you participate in a demonstration/seminar or any other activity at DH/CHC/PHC/SC, it should be countersigned by the respective counsellor under whom the activities had been carried out.

You will be evaluated for internal assessment in PSC/DH/CHC and PHC. Your counselor will inform you in advance about the case to be evaluated. The cases for evaluation will be provided by your counselor.

In urban health centre you will prepare a report of activities observed or performed.

As mentioned above you will be posted in various inpatient and outpatient departments in various health facilities DH, CHC, PHC. You will also be posted in subcentre and urban health centre.

During your posting, the counselor will monitor your activities. The details of posting are given below in Table 1. Proforma for monitoring is given in Appendix 2.

**Proposed area wise distribution of Activity as per areas of a health facility**

<table>
<thead>
<tr>
<th>Activity 1</th>
<th>Community Assessment and Identification of Common Health Problems</th>
<th>community/field</th>
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</thead>
<tbody>
<tr>
<td>Activity 2</td>
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<td>Activity 5</td>
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<tr>
<td>Activity 6</td>
<td>Identification and appropriate management of communicable diseases</td>
<td>Outpatient/Inpatient/community/family/field</td>
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<tr>
<td>Activity 7</td>
<td>Identification and appropriate management</td>
<td>Outpatient/Inpatient/community/family/field</td>
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<tr>
<td>Activity</td>
<td>Description</td>
<td>Location</td>
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<tr>
<td>Activity 8</td>
<td>Social Mobilization Skills</td>
<td>community/field visit</td>
</tr>
<tr>
<td>Activity 9</td>
<td>Health Education/Counseling</td>
<td>Outpatient/Inpatient/community/family/field</td>
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<tr>
<td>Activity 10</td>
<td>Recording and Reporting Format</td>
<td>Outpatient/Inpatient/community Health Centre /family/field</td>
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<tr>
<td>Activity 11</td>
<td>Hand Washing Skills</td>
<td>Outpatient/Inpatient/community/family/field</td>
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<tr>
<td>Activity 12</td>
<td>Bio-medical Waste Management</td>
<td>Inpatient departments and sub-centre</td>
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<td>Activity 13</td>
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<td>Activity 14</td>
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<td>Outpatient/Inpatient/community/family/field/SC</td>
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<tr>
<td>Activity 15</td>
<td>Examination of Lumps</td>
<td>Outpatient/Inpatient/community/family/field/SC/Clinics</td>
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<td>Activity 16</td>
<td>Assessment of the patient with eye pain</td>
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<td>Activity 17</td>
<td>Assessment of the patient with Ear, Nose and Throat (ENT) problems</td>
<td>Outpatient/Inpatient/community/family/field/SC/Clinics</td>
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<td>Activity 18</td>
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<td>Outpatient/Inpatient/community/family/field/Clinics</td>
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<tr>
<td>Activity 19</td>
<td>Suturing of superficial Wounds</td>
<td>Outpatient/Inpatient/SC</td>
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<td>Activity 20</td>
<td>Basic Life Support</td>
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<td>Activity 22</td>
<td>Aches and Pain</td>
<td>Outpatient/Inpatient/community/family/field visit / SC</td>
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<tr>
<td>Activity 26</td>
<td>Assessment and care of</td>
<td>Outpatient/community/family/field visit / SC</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Location</td>
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</tr>
<tr>
<td>27</td>
<td>Monitoring labour and maintaining partograph</td>
<td>Inpatient department /SC</td>
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<td>28</td>
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<td>Outpatient/Inpatient/community/family/field visit / SC</td>
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<td>29</td>
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<td>30</td>
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<td>Outpatient/Inpatient/Health Centre</td>
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<tr>
<td>35</td>
<td>Management of abortion and counseling</td>
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</tr>
<tr>
<td>36</td>
<td>Adolescent Counseling</td>
<td>Outpatient/Inpatient/community/family/field visit</td>
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<tr>
<td>37</td>
<td>Resuscitation of New Born</td>
<td>Inpatient Department</td>
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<td>38</td>
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<td>Inpatient Department</td>
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<tr>
<td>39</td>
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<td>Outpatient/Inpatient/community/family/field visit</td>
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<td>40</td>
<td>Infant and Young Child Feeding</td>
<td>Outpatient/Inpatient/community/family/field visit</td>
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<tr>
<td>41</td>
<td>Promoting and Monitoring Growth and Development and Plotting Chart</td>
<td>Outpatient/Inpatient/community/family/field visit</td>
</tr>
<tr>
<td>42</td>
<td>Immunization and safe injection practices</td>
<td>Under five clinic/community/family/field visit</td>
</tr>
<tr>
<td>43</td>
<td>Use of Equipments</td>
<td>Health Facility</td>
</tr>
</tbody>
</table>
The list provides the minimum number of patients to be seen by you at various places of posting. You are free to see as many cases as you get the opportunity or perform in as many activities as you get opportunity. But make an entry for those cases/activities also in respective columns. You will maintain record of 2 cases in log book in each health facility DH/CHC/PHC/SC/UC. However record for all other activities has to be maintained in blank sheet /format provided and signed by the Counsellor.

**Minimum Number of Patients to be seen for Each Skill**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Place of Posting and Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DH (Minimum)</td>
</tr>
<tr>
<td>Activity 1: Community Assessment (CNA) and Identification of Common Health Problems</td>
<td>1</td>
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<tr>
<td>Activity 2: Health Assessment of an individual</td>
<td>2</td>
</tr>
<tr>
<td>Activity 3: Nutritional Assessment and assessment of nutritional deficiencies</td>
<td>2</td>
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<tr>
<td>Activity 4: Organizing and Conducting Special Clinics</td>
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<td>Activity 35: Management of abortion and counseling</td>
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<tr>
<td>Activity 43: Use of Equipments</td>
<td>2</td>
</tr>
</tbody>
</table>

**PRESENTATION OF BRIEF REPORT**
1.5 HOW YOU WILL BE EVALUATED

Continuous Evaluation

There will be continuous evaluation during your posting and practical examination at the end of practical experience.

Continuous evaluation will carry 30 marks. You need to score 50% marks to pass to be eligible for appearing in practical examination.

You will be evaluated for continuous evaluation at DH and CHC. At DH counselor will assign you any two patients/case for which you will be required to prepare report for evaluation.

Similarly you will also be assigned two cases/patients in CHC and you will be required to prepare report for evaluation. Maintenance of Log book will carry 5 marks

The scheme for continuous evaluation is given below:

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>No. of cases and marks</th>
<th>Total cases and Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Case-1</td>
<td>Case-2</td>
</tr>
<tr>
<td>District Hospital (DH)</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Community Health Centre (CHC)</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Maintenance of Log Book</td>
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<td><strong>Total</strong></td>
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</table>

Practical Examination

Practical examination will carry 70 marks. You will have to submit the following to the Programme In-charge who will also be a Superintendent of practical examination.

a. Attendance Certificate of Completion of Practical Training at each health facility DH/CHC/PHC/SC/UC. The proforma is attached at Appendix-3.
b. Certificate of Eligibility for Term-End Examination (Practical only). The proforma is attached at Appendix-4.
c. Proforma for pattern of Practical examination is given at appendix 5.
### 1.6 DETAILS OF POSTING UNDERGONE

You should prepare a list of all your postings with dates and record in the following table and get it signed by the respective counselor. This will help you to get a completion certificate sign at the end of posting to enable you to appear in practical examination.

#### DISTRICT HOSPITAL (DH)

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Department</th>
<th>Name of the Counselor</th>
<th>Date of Posting</th>
<th>Signature of the Counselor</th>
</tr>
</thead>
<tbody>
<tr>
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<td>From</td>
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## Primary Health Centre (PHC)

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## Sub Centre (SC)

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</table>
**Activity -1: Community Assessment and Identification of Common Health Problems (PSC/DH-1)**

Guidelines:
- Identify a team of health workers and consultative team working in a Selected community
- Assess the activities carried out by each team
- Record the information in a given format
- Record your findings to be collected from the records available at Sub-centre

Name of the Health Facility _____________________ Date: ______________

Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: ____________
- c. Age_______
- d. Religion_______
- e. Education____________
- f. Occupation_______
- g. Monthly income________
- h. Gender :Male/Female ____________
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

Use the given format

<table>
<thead>
<tr>
<th>S.No</th>
<th>Areas</th>
<th>Activities</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Working Team at Village level</td>
<td>Identify Anganwadi workers/ Traditional Birth Attendants/ Mahila Swasthya Sangh or any equivalent group/ ASHA and leaders of youth organization.</td>
<td></td>
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<tr>
<td></td>
<td>Activities of the team</td>
<td>Conduct household surveys, Collection of relevant information and report birth, death, marriage, epidemics etc.</td>
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<td>2</td>
<td>Consultative team</td>
<td>Identify Panchayati Raj members/ Teachers/ Religious Leaders/Priests/Members of NGOs/informal organizations</td>
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</tbody>
</table>
## Activities of the team

Collaborate with the working team for collection of relevant information and reporting of the major events such as regular meetings, planning and provision of services, discussion of the priority issues, the actions taken and their results.

<table>
<thead>
<tr>
<th>3</th>
<th>Primary health centre (PHC) level/ CHC level/ SC level</th>
<th>Services and supplies</th>
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<th>Identifying Health Indicators</th>
<th>Mortality indicators</th>
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<td></td>
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<td>• Crude death rate</td>
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<td>• Age specific death rates:</td>
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<td>• Maternal mortality rate:</td>
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<td>• Case fatality rate</td>
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<td><strong>Morbidity indicators</strong></td>
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<td>• Incidence and prevalence rate</td>
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<td>• Notification rates</td>
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<td>• Admission, re-admission rates and discharge rates.</td>
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<td>• Out-patient department (OPD) attendance</td>
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**Disability indicators (Please specify from the records of sub centre)**

**Nutritional status indicators**

• Anthropometric measurements of new borns head circumference, chest circumference.
• Prevalence of low birth weight (weight at birth less than 2.5 Kg).
• Other indicators include: weight for age, height for age.
• Anthropometric measurements of school children like height, weight, mid-arm circumference.

**Fertility indicators (Please specify from the records of sub centre)**

• Birth rate:
• General fertility rate:
• General Marital Fertility rate:
• Age specific fertility rate:
• Age specific marital fertility rate:
• Total fertility rate:
• Total marital fertility rate:
• Gross Reproduction Rate:
• Net Reproduction Rate:
• Other indicators: Child woman ratio, pregnancy rate, abortion rate, abortion ratio, marriage rate.

Health care delivery indicators (whichever is applicable)
• Doctor population ratio
• Doctor nurse ratio
• Population bed ratio
• Population per health centre

Utilization rates
Utilization of services is expressed as proportion of people in need of a service who actually receive it in a given period

Indicators of social and mental health
Suicide/ homicide/ road traffic accidents/ juvenile delinquency/ alcohol and drug abuse etc.

Environmental indicators
Air or water pollution, proportion of population having access to safe water and sanitation facilities.

Socio-economic indicators
Level of unemployment/ dependency ratio/ per capita calorie availability/ and literacy rates etc.

Health policy indicators
Proportion of Gross Net Product (GNP) spent on health services/ Proportion of total health resources spent on primary/ secondary and tertiary care.
<table>
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<tr>
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<th>Social and environmental determinants of health</th>
<th>Determinants of Health (Ask from ANM and Record whichever applicable)</th>
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<td>Literacy status</td>
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<td>Environment</td>
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<td>Socio-cultural conditions</td>
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<td>Other factors</td>
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(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
**Activity -1: Community Assessment and Identification of Common Health Problems**

(PSC/DH-2)

Name of the Health Facility _____________________ Date: _____________

Date of Registration:_______ Registration No.________

**Identification Data:**
- d. Name _______
- e. Relationship with head of family: ___________
- f. Age______
- g. Monthly income_________
- h. Gender :Male/Female_________
- i. Marital Status ____________
- j. Address_________
- k. Contact No._______

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**Signature of the Academic Counselor /Supervisor**
Activity -1: Community Assessment and Identification of Common Health Problems (CHC-1)

Name of the Health Facility _____________________ Date: ________________

Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: ____________
- c. Age______
- d. Religion_______
- e. Education ________
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(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
### Activity -1: Community Assessment and Identification of Common Health Problems (CHC-2)

Name of the Health Facility _____________________ Date: __________

Date of Registration: _______ Registration No. ________

**Identification Data:**

- **a. Name:** _______
- **b. Relationship with head of family:** _________
- **c. Age:** _______  
- **d. Religion:** _______
- **e. Education:** ____________
- **f. Occupation:** _______
- **g. Monthly income:** ________
- **h. Gender : Male/Female:** _______
- **i. Marital Status:** ____________
- **j. Address:** ____________
- **k. Contact No.:** ___________

(Attached additional sheets if required)

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Signature of the Academic Counselor /Supervisor

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22
Activity -1: Community Assessment and Identification of Common Health Problems (PHC-1)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. ________

**Identification Data:**

a. Name _______

b. Relationship with head of family: ___________

c. Age______

d. Religion_____

e. Education ____________

f. Occupation_____

d. Monthly income________

h. Gender : Male/Female __________

i. Marital Status ____________

j. Address_________

k. Contact No. ________

(Attached additional sheets if required)

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Signature of the Academic Counselor / Supervisor

23
**Activity -1: Community Assessment and Identification of Common Health Problems (PHC-2)**

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______
b. Relationship with head of family: _____________
c. Age______
d. Religion______
e. Education ______________
f. Occupation_____
g. Monthly income ____________
h. Gender :Male/Female ____________
i. Marital Status ____________
j. Address_________
k. Contact No._______

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(Attach additional sheets if required)

**Signature of the Academic Counselor /Supervisor**
Activity -1: Community Assessment and Identification of Common Health Problems  

Name of the Health Facility ___________________ Date: ________________

Date of Registration: _______ Registration No. ________

Identification Data:
  a. Name ________
  b. Relationship with head of family: _____________
  c. Age ________
  d. Religion ________
  e. Education ________________
  f. Occupation ________
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  h. Gender : Male/Female ________
  i. Marital Status ________________
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  k. Contact No. ________

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Signature of the Academic Counselor / Supervisor
Activity -1: Community Assessment and Identification of Common Health Problems (SC-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
a. Name _______
b. Relationship with head of family: ___________
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<th>Findings</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 2: Health Assessment of an individual (PSC/DH-1)

Guidelines:
- using guidelines given in BNSL-043, identify health problems if any
- make health assessment of an individual
- record the findings in the format given in log book

Select any two cases in a selected community of Health facility (DH)

Using guidelines given in BNSL-043 identify health problems if any make health assessment of an individual record the findings in the format given in log book

Name of the Health Facility __________________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
- a.Name _______
- b.Relationship with head of family: ___________
- c.Age___________
- d. Religion_______
- e. Education _____________
- f. Occupation_______
- g. Monthly income________
- h. Gender :Male/Female __________
- i.Marital Status ___________
- j. Address_________
- k. Contact No._______

Format for Health Assessment

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<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management/Report</th>
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<tbody>
<tr>
<td>• Habits: Smoking/ alcohol Drug/ Tobacco/ Excessive tea or coffee</td>
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<td>• Diet: Vegetarian/ Non vegetarian/ egg vegetarian</td>
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<td>• Life style: Sedentary/ exercise/ relaxation/ Yoga/ meditation/ any other</td>
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<td>• Hobbies: _______</td>
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<td>• Hygiene: Good/ Fair/ poor</td>
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<td>• Rest and sleep: adequate / inadequate</td>
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<td>• Elimination habits: Bowel: Good/ Fair/ Poor</td>
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<td>• Bladder: Good/ fair/ Poor</td>
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</table>

Personal Medical History
- Childhood disease (Specify)
- Immunization status (completed / not
completed or any other

- **Allergies** (Yes / No, if yes please specify)
- **History of illness**

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<thead>
<tr>
<th><strong>Psychosocial History</strong> : (Ask and Record)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Any Mental illness in the family, specify.</td>
</tr>
<tr>
<td>- <strong>Supportive system</strong>: Husband/ family and others</td>
</tr>
<tr>
<td>- <strong>Stressors</strong>: Occupational or personal</td>
</tr>
<tr>
<td>- Past history of depression or suicidal tendency</td>
</tr>
<tr>
<td>- Emotional changes</td>
</tr>
<tr>
<td>- Adjustment to circumstances</td>
</tr>
<tr>
<td>- History of any domestic violence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Family History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Health status of Parents/ siblings (if deceased, mention cause of death)</td>
</tr>
<tr>
<td>- History of the following diseases in Parents/siblings/ Close relatives (specify)</td>
</tr>
<tr>
<td>- Diabetes mellitus/Hypertension/Heart disease/Stroke</td>
</tr>
<tr>
<td>- Congenital disease/Asthma/Cancer (specify)/Multiple pregnancy/ Complication of pregnancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Physical Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Height</td>
</tr>
<tr>
<td>- Weight</td>
</tr>
<tr>
<td>- Body Mass Index</td>
</tr>
<tr>
<td>- Blood Pressure</td>
</tr>
<tr>
<td>- Vital signs: Temperature, Pulse, Respiration</td>
</tr>
<tr>
<td>- Oral Examination</td>
</tr>
<tr>
<td>- Abrasion/Bruises</td>
</tr>
<tr>
<td>- Ulceration/Oedema/Injury/Bad breath</td>
</tr>
<tr>
<td>- H/o smoking/ tobacco consumption</td>
</tr>
<tr>
<td>- Check for loose teeth/broken teeth/missing teeth/decayed teeth.</td>
</tr>
<tr>
<td>- <strong>Nutritional Assessment</strong></td>
</tr>
<tr>
<td>- Pallor/ vitamin deficiency/ mineral deficiency</td>
</tr>
<tr>
<td>- <strong>Abdominal examination</strong></td>
</tr>
<tr>
<td>- Tenderness/Abdominal scars/ any lesions/</td>
</tr>
<tr>
<td>- Palpation – Palpate suprapubic, right iliac fossa and left iliac fossa regions and identify masses/Pain/Tenderness/ Palpable lymph nodes in groin</td>
</tr>
</tbody>
</table>
- External genitalia: Observe for skin conditions or lesions/Erythema/Excoriation/Distribution of pubic hair/Introital bleeding or discharge/any other

<table>
<thead>
<tr>
<th>Head to toe examination (specify if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hair and scalp - healthy or infected</td>
</tr>
<tr>
<td>- Eyes - Color of conjunctiva, sclera, any discharge or signs of infection Ear, Nose and Throat - healthy, enlarged or signs of infection</td>
</tr>
<tr>
<td>- Mouth, gums and teeth - Hygiene, cavities or signs of infection</td>
</tr>
<tr>
<td>- Skin - any scar or sign of infection</td>
</tr>
<tr>
<td>- Extremities</td>
</tr>
<tr>
<td>Upper – check hand and colour and shape of nails</td>
</tr>
<tr>
<td>Lower – any pain, tenderness, oedema or varicose veins</td>
</tr>
<tr>
<td>- Back and spine - observe for any deformity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Complete Blood Count</td>
</tr>
<tr>
<td>Hemoglobin/ESR/WBC/TLC/DLC/Serum</td>
</tr>
<tr>
<td>Cholesterol/ Lipid profile/Blood sugar/HIV Test/Urine for Pregnancy test</td>
</tr>
</tbody>
</table>

Utilization of Health facility by women or Family members:__________________________

**Health education given**

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 2: Health Assessment of an individual  

(PSC/DH-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______

b. Relationship with head of family: ____________

c. Age______

d. Religion_______

e. Education ________________

f. Occupation______

g. Monthly income __________

h. Gender :Male/Female __________

i. Marital Status ____________

j. Address_________

k. Contact No._______

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management/Report</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 2: Health Assessment of an individual

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: ___________
   c. Age______
   d. Religion______
   e. Education ____________
   f. Occupation______
   g. Monthly income __________
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
**Activity 2: Health Assessment of an individual (CHC-2)**

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: ___________
- c. Age______
- d. Religion______
- e. Education __________
- f. Occupation_____
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

<table>
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<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management/Report</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor /Supervisor**

32
Activity 2: Health Assessment of an individual (PHC-1)

Name of the Health Facility _____________________ Date:____________

Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: ___________

c. Age______

d. Religion_______

e. Education _____________

f. Occupation_______

g. Monthly income _________

h. Gender : Male/Female _________

i. Marital Status ____________

j. Address_________

k. Contact No._______

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management/Report</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

33
**Activity 2: Health Assessment of an individual**

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**
a. Name _______
b. Relationship with head of family: __________
c. Age______ d. Religion______
e. Education ____________ f. Occupation______
g. Monthly income _________ h. Gender :Male/Female _________
i. Marital Status ____________ j. Address__________
j. Contact No._______

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management/Report</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 2: Health Assessment of an individual

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: ___________
  c. Age______
  d. Religion______
  e. Education __________
  f. Occupation_____
  g. Monthly income _______
  h. Gender :Male/Female __________
  i. Marital Status __________
  j. Address_________
  k. Contact No._______

<table>
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<tr>
<th>Personal History</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 2: Health Assessment of an individual

Name of the Health Facility _____________________ Date:____________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: __________
  c. Age______
  d. Religion______
  e. Education ____________
  f. Occupation______
  g. Monthly income ____________
  h. Gender :Male/Female __________
  i. Marital Status __________
  j. Address_________
  k. Contact No._______

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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies

(PSC/DH-1)

Guidelines:

Select 2 children under 5 years of age
• perform nutritional assessment
• identify any deficiency
• give appropriate care as per need
• make appropriate referral if required
• record the findings and action taken in log book

Name of the Health Facility _____________________ Date: ___________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  c. Age______
  d. Religion______
  e. Education ____________
  f. Occupation______
  g. Monthly income ____________
  h. Gender :Male/Female ____________
  i. Marital Status ____________
  j. Address ____________
  k. Contact No.__________

Format for Nutritional Assessment and identification of Nutritional deficiencies

<table>
<thead>
<tr>
<th>Areas of Assessment</th>
<th>Findings</th>
<th>Management / Referal</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of present illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of past medical illness /Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h/o medical illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthropometric Measurement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest circumference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid Arm circumference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other parameter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record the findings in (growth chart)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note: Fill up growth Chart
**Assessment of Marasmus and Kwashiorkor, Vitamin and Mineral deficiency disorders**

<table>
<thead>
<tr>
<th>Marasmus</th>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wasting of subcutaneous fat and muscles (flabby muscles)/Wizened monkey (old man face)/Increased appetite sunken eye balls/mood change (always irritable) and/mild skin and hair changes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Kwashiorkor**

Growth failure/wasting of muscles and preservation of subcutaneous fat/edema fatty liver/difficulty in walking/moon face due to hanging cheeks/loss of appetite/lack of interest in the surrounding/skin changes (ulceration and depigmentation or hyperpigmentation)/hair changes (depigmentation, straightening of hair and presence of different color brands of the hair Straightening of hair at the bottom and curling on top (Forest sign) / easily pluckable hair.
<table>
<thead>
<tr>
<th>Vitamin</th>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Reduced vision in the night or dim light/Dry eyes /Eye inflammation</td>
<td></td>
</tr>
<tr>
<td>B1</td>
<td>(Thiamine) H/oWeight loss/Emotional disturbances/Wernicke’s encephalopathy (impaired sensory perception) - ataxia (unsteadiness) - impaired consciousness - problems of eye movement/ - Weakness and pain in the limbs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Muscle pain – typically in the calves Congestive cardiac failure – - shortness of breath - fluid retention - rapid and sometimes bounding pulse/ loss of sensation and strength in the hands or lower limbs - Korsakoff’s Psychosis – loss of memory both recent (anterograde) and past</td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td>(Riboflavin) Cheilosis (cracks in the lips)/High sensitivity to sunlight/ /Glossitis (inflammation of the tongue)/ Seborrhic dermatitis or pseudo syphilis (particularly affecting the scrotum or labia majora and the mouth/Pharyngitis (sore throat)/Edema of the pharyngeal or oral mucosa</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>(Niacin) Nausea/Abdominal cramps/Severe deficiency - mental confusion</td>
<td></td>
</tr>
<tr>
<td>B6</td>
<td>(pyridoxine) Anemia/Skin disorders, such as a rash or cracks around the mouth./ Depression/Confusion/Pink eye/Epilepsy</td>
<td></td>
</tr>
<tr>
<td>B9</td>
<td>(Folic Acid) Macrocytic anaemia/Birth defects</td>
<td></td>
</tr>
<tr>
<td>B12</td>
<td>(Cobalmin) Tingling in the feet and hands/Extreme fatigue/Weakness/ Irritability or depression/Memory Loss/Cognitive Defects</td>
<td></td>
</tr>
<tr>
<td>Minerals Deficiency disorders</td>
<td>Findings</td>
<td>Action Taken</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Anaemia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath/Dizziness/Headache/Coldness in hands and feet/Pale skin/Chest pain/Weakness/Fatigue (Tiredness)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Calcium Deficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle aches &amp; cramps/Tooth Decay/Weak or deformed bones/brittle nails &amp; dry skin/Heart Disease/Allergies/Chronic Arthritis/Headaches/ Common Colds, Flu, Infections.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Iodine or thyroid deficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brittle nails/Cold hands and feet/Cold intolerance/Depression/Difficulty swallowing/Dry skin/ Dry hair or hair loss/Fatigue / lethargy/ Hoarseness/Menstrual irregularities/Poor memory or concentration/Slower heartbeat/Throat pain/Weight gain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies

(PSC/DH-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: ___________
c. Age______
d. Religion______
e. Education __________
f. Occupation______
g. Monthly income ______
h. Gender : Male/Female __________
i. Marital Status __________
j. Address_________
k. Contact No._______

Format for Nutritional Assessment and identification of Nutritional deficiencies

<table>
<thead>
<tr>
<th>Areas of Assessment</th>
<th>Findings</th>
<th>Management / Referal</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor / Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies (CHC-1)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: ____________
  c. Age______
  d. Religion______
  e. Education ____________
  f. Occupation______
  g. Monthly income _________
  h. Gender :Male/Female _________
  i. Marital Status ____________
  j. Address_________
  k. Contact No._______

Format for Nutritional Assessment and identification of Nutritional deficiencies

<table>
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<tr>
<th>Areas of Assessment</th>
<th>Findings</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies
(CHC-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**
a. Name _______
b. Relationship with head of family: ___________
c. Age______
d. Religion______
e. Education ___________
f. Occupation______
g. Monthly income ___________
h. Gender :Male/Female _________
i. Marital Status ______________
j. Address_________
k. Contact No._______

**Format for Nutritional Assessment and identification of Nutritional deficiencies**

<table>
<thead>
<tr>
<th>Areas of Assessment</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies

(PhC-1)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age______  
d. Religion_______

e. Education_____________  
f. Occupation_________

g. Monthly income ___________  
h. Gender :Male/Female ___________

i. Marital Status ________________  
j. Address_______________

k. Contact No._______

Format for Nutritional Assessment and identification of Nutritional deficiencies

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(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
**Activity 3: Nutritional Assessment and assessment of nutritional deficiencies**

*(PHC-2)*

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _________

c. Age______

d. Religion______

e. Education______________

f. Occupation_____

g. Monthly income ____________

h. Gender :Male/Female ___________

i. Marital Status ______________

j. Address_________

k. Contact No._______

Format for Nutritional Assessment and identification of Nutritional deficiencies

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(Attach additional sheets if required)

__________________________________________
Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies (SC-1)

Name of the Health Facility _____________________ Date:_____________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: ____________
  c. Age______
  d. Religion______
  e. Education __________
  f. Occupation______
  g. Monthly income ________
  h. Gender :Male/Female ________
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  j. Address________
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Format for Nutritional Assessment and identification of Nutritional deficiencies

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Signature of the Academic Counselor /Supervisor
Activity 3: Nutritional Assessment and assessment of nutritional deficiencies

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age______
  d. Religion_______
  e. Education __________
  f. Occupation________
  g. Monthly income __________
  h. Gender :Male/Female __________
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Format for Nutritional Assessment and identification of Nutritional deficiencies

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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 4: Organizing and Conducting Special Clinics (PSC/DH-1)

Guidelines:

1. Participate in organizing and counseling special clinics at various health facilities such as DH/CHC/PHC/SC
2. Observe the activities being carried out in each special clinic by various health functionaries as per the format given below (A)
3. Participate and carry out the activities in various special clinics
4. Fill up the information give in the following format (B)
5. Refer Unit-4 Block -1 BNSL-043 for the details of the activities

Identification Data:

a. Name_________

b. Relationship with head of family: ___________

c. Age_________

d. Religion_________

e. Education_________

f. Occupation_______

g. Monthly income_________

h. Gender: Male/Female ________

i. Marital Status ________

j. Address_________

k. Contact No._______

A. Format for various activities to be carried out at Special Clinics – NCD Clinics

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub centre</strong></td>
<td>1. Health promotions for behavior change</td>
</tr>
<tr>
<td></td>
<td>2. “Opportunistic” Screening Using B.P measurement and blood glucose by strip method</td>
</tr>
<tr>
<td></td>
<td>3. Referral of suspected cases to CHC</td>
</tr>
<tr>
<td><strong>CHC</strong></td>
<td>1. Prevention and health promotion including counseling</td>
</tr>
<tr>
<td></td>
<td>2. Early diagnosis through clinical and laboratory investigations (Common lab investigations: Blood Sugar, lipid profile, ECG, Ultrasound, X ray etc.)</td>
</tr>
<tr>
<td></td>
<td>3. Management of common CVD, diabetes and stroke cases (out patient and in patients.)</td>
</tr>
<tr>
<td></td>
<td>4. Home based care for bed ridden chronic cases</td>
</tr>
<tr>
<td></td>
<td>5. Referral of difficult cases to District Hospital/higher health care facility.</td>
</tr>
<tr>
<td><strong>District Hospital</strong></td>
<td>1. Early diagnosis of diabetes, CVDs, Stroke and cancer</td>
</tr>
<tr>
<td></td>
<td>2. Investigations:</td>
</tr>
<tr>
<td></td>
<td>• Blood Sugar,</td>
</tr>
</tbody>
</table>
- lipid profile,
- Kidney function Test (KFT),
- Liver Function test (LFT),
- ECG, Ultrasound,
- X ray,
- Colonoscopy,
- Mammography etc. (if not available, will be outsourced)

3. Medical management of cases (out patient, inpatient and intensive care)
4. Follow up and care of bed ridden cases
5. Day care facility
6. Referral of difficult cases to higher health care facility
7. Health promotions for behavior change

<table>
<thead>
<tr>
<th>S.No</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Opportunistic Screening</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Detailed Investigation</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Outsourcing of Certain Laboratory Investigations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>4</td>
<td>Out-patient and In-patient Care</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Day care Chemotherapy Facility</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Home based palliative care</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Referral &amp; Transport facility to serious patients</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Health Promotion</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Data</td>
<td></td>
</tr>
</tbody>
</table>
recording and reporting

**Human Resources requirement**
- Doctor (specialist in Diabetology/cardiology/M.D Physician)
- Medical Oncologist
- Cyto-pathologist
- Cytopathology Technician
- Nurses (4): 2 for day care, one for cardiac care Unit, one for O.P.D
- Physiotherapist
- Counselor
- Data Entry Operator
- Care coordinator

**Community Health Centre (CHC)**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Screening of NCD</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Prevention and health promotion</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Laboratory investigations</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Identification and Management</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Home based care</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>S.No.</td>
<td>Activity</td>
<td>Findings</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>1</td>
<td>Home visits</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HWC/SC or Village (fixed day/week)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Navigation services</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Document and record maintenance</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Health Centre (PHC) and Sub-Centre (SC)**

**Format for activity at Family Planning Clinics**

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Activity</th>
<th>Findings</th>
<th>Management /Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Observe availability of Manpower in the clinic and patients or beneficiaries coming for availing services. Methods of creating awareness among the beneficiaries. • The proper spacing and limitation of births • Advice on sterility • Education for parenthood • Sex education • Screening for pathological conditions related to the reproductive system</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(cervical cancer)
- Genetic counseling
- Premarital consultation and examination
- Carrying out pregnancy tests
- Marriage counseling
- The preparation of couples for the arrival of their first child
- Providing services for unmarried mothers
- Teaching home economics and nutrition
- Providing adoption services
- These activities vary from country to country to national objectives and policies with regard to family planning this is the modern concept of family planning.

2 Observe and participate in maintaining register

Maternal and Child Health Clinic

1
- All newly registered mothers.
- Mothers showing signs of toxemia, bleeding, anaemia or other abnormalities.
- Mothers with history of complications.
- Primigravidae.
- Mothers who have had more than five pregnancies.
- Take the history of past and present health, complaints and pertinent facts about family conditions including history of treatment or exposure to syphilis, tuberculosis, leprosy or other communicable diseases.
- Make tests for haemoglobin, urinalysis, blood pressure, and take pelvic measurements. Collect specimen for the laboratory such as stool, blood for syphilis and malaria smear.
- Observe and record signs and symptoms of deviation from normal.
- Obtain and record reports of laboratory
and other tests.

- Weigh each mother and take temperature if indicated.
- Note diet and nutritional status.

### Adolescent Wellness Clinic

| 1 | i) Clinical Services: |
|   | ii) General Examination. |
|   | - Nutrition advice. |
|   | - Detection and treatment of anemia. |
|   | - Easy and confidential access to medical termination of pregnancy. |
|   | - Antenatal care and advice regarding child birth. |
|   | - RTIS and STIS detection and treatment. |
|   | - HIV detection and counseling. |
|   | - Treatment of psychosomatic problems. |
|   | - De- addiction |
|   | - Other health concerns. |

### iii) Counseling Services

### iv) Scheme for Promotion of mental Health

### v) Scheme for Promotion of Menstrual Hygiene among Adolescent girls in Rural India

### vi) Preventive Health Checkups and Screening for Diseases, Deficiency and Disability

### vii) Health Problems

### viii) Reproductive Health Problems

### ix) Behavioral Problems

### x) Nutritional Problems

Priority Intervention under NRHM and RCH

- Adolescent nutrition; iron and folic acid supplementation
- Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
- Information and counseling on adolescent sexual reproductive health and other health issues
- Menstrual hygiene
- Preventive health checkups
### Oral Health Clinics

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 1 | • Regular Dental Checkups of individuals and diagnosis at primary level.  
  • Preventive services by health education of individuals, groups, families.  
  • Interceptive and curative services to the community at large and school children.  
  • Referral to the dental clinics at tertiary level if required. |

### Assessment | Findings | Management Referral

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History - present illness / Psychiatric and medical history / AOD / Psychosocial/Developmental History (Personal History) / Social History / Family History</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Assessment-/History /Psychosocial/developmental and personal history/Mental State/Cognitive Assessment/Substance Use /Medical/Biological – physical assessment /Risk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| Investigations as required -blood and urine  
For nervous system problem – EEG, MRI/ CT Scan  
For other problems – thyroid function test, electrolyte levels and toxicology screening |   |   |

### Mental Status Examination

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance and behavior/Hair and eye colour, ethnic origin, stature and posture./ grooming, hygiene, clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial characteristics: furrowing of brow, tear-rimmed eyes facial expression and eye contact./kempt or unkempt, personal hygiene standards (including body odour)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General behaviour of the patient: disinhibition, psychomotor retardation, any sign of response to hallucinatory experiences.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Patient’s response to the strange situation of the interview 
Motor behaviour :agitation, repetitive behaviour tremors, restless 
Reaction to situation: hostile, friendly, withdrawn, uncommunicative |
| Rapport building with patient and his/her family members |
| Speech :Relates to the physical aspects : rate/volume/quantity of information supplied |
| Mood :different aspects of mood |
| Affect: Observe : Normal / Restricted / decrease in intensity and range of emotional expression / Blunted - severe decrease in intensity and range |
**Thought**
Form of Thought Assessed by what and how the person says  
Amount of thought produced -poverty of thought/ flight of ideas  
Continuity of ideas : logical flow of ideas, ability to stick with the topic/ circumstantial, tangential, thought blocking Disturbances in language: use of words that do not exist or incoherent conversations/neologisms, word approximations

**Perception**: record any abnormalities in the way in which the patient perceives the world

Cognition - whether the patient is oriented in time, person and place. Level of Consciousness/Memory Orientation/ Concentration/Abstract thoughts/Judgement

**Insight**: the individuals awareness /understanding of their situation

**Depressive disorders**  
Sad and irritable/Feelings of restlessness/Lethargy/Distractibility  
Feels hopeless and empty/Weight loss or gain /Inability to sleep/excessive sleep/Feelings of worthlessness or excessive guilt/Recurrent thoughts of death/Suicidal thoughts or plans/  
Physical symptoms like non specific pains, marked loss of interest or pleasure
| Anxiety Disorders |  |
| Excessive fear to real or perceived threat/ Specific fears/phobias- fear of heights, flying or public speaking./ Generalized feelings of worry and tension |  |

| Attention Deficit Hyperactivity Disorder (ADHD) |  |
| Children -less attentive in class and cannot focus on the task given/Difficulty in controlling behavior/Hyperactive/Poor performers/Easily distracted/Talk excessively/Adults - extremely distractible and have difficulties with organization |  |

| Bipolar and Related Disorders |  |
| Sudden mood swings/  |
| Behavioral changes - fatigue or loss of energy/Sudden significant weight changes/Complaining about pain/ Suicidal thoughts or plans |  |

| Disruptive, Impulse Control, and Conduct Disorders |  |
| Problem with control on their emotions or behavior |  |
### Oppositional defiant disorder (ODD)

- Excessive anger/irritability/Argumentative/defiant behavior/Vindictiveness/Lose their temper/Frequently pick up fights/Resentful/ Easily get annoyed/ Refuse to comply with rules/Argumentative/Deliberately annoy others or blame others

### Conduct disorder (CD)

- Disrupt the social norm/Aggression to people and animals/ Destruction of property/Serious violations of rules

### Obsessive-Compulsive and Related Disorders (OCD)

- Unwanted thoughts, urges, or images/
  - Repeats behavior ritualistically

### Schizophrenia

- Delusions of false and persistent beliefs/Hallucinations/Disorganized speech/Grossly disorganized behavior/Disillusionment with life -stay isolated, not motivated and speaks infrequently

### Trauma- and Stress-Related Disorders

- Flashbacks or recurring upsetting dream/Upsetting memories/ Psychological disturbances/Avoidance of stimuli associated with the traumatic event/Mood changes/Changing a personal routine/Getting tense

### Substance Abuse
<table>
<thead>
<tr>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Type of drug</td>
<td></td>
</tr>
<tr>
<td>- Frequency of use</td>
<td></td>
</tr>
<tr>
<td>- Average daily intake — no. injections/day</td>
<td></td>
</tr>
<tr>
<td>- Duration of this episode, time and date of last use.</td>
<td></td>
</tr>
<tr>
<td>- Signs and symptoms when you stop substance intake</td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 4: Organizing and Conducting Special Clinics  

(PSC/DH-2)

**Identification Data:**

a. Name _______

b. Relationship with head of family: _____________

c. Age _______  
d. Religion_______

e. Education ___________  
f. Occupation_____

g. Monthly income ___________  
h. Gender : Male/Female __________

i. Marital Status ___________  
j. Address_________

k. Contact No._______

**Format for various activities to be carried out at Special Clinics – NCD Clinics**

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Services</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 4: Organizing and Conducting Special Clinics (CHC-1)

Identification Data:

a. Name _______
b. Relationship with head of family: ____________
c. Age ______
d. Religion _______
e. Education ____________
f. Occupation _______
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h. Gender : Male/Female ____________
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k. Address ______

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Activity 4: Organizing and Conducting Special Clinics  

Identification Data:

a. Name ________
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c. Age _________
d. Religion ________
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f. Occupation ________
g. Monthly income __________
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k. Marital Status ____________
k. Contact No. _______

C. Format for various activities to be carried out at Special Clinics – NCD Clinics

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Signature of the Academic Counselor/Supervisor
Activity 4: Organizing and Conducting Special Clinics  (PHC-1)

**Identification Data:**

a. Name _______

b. Relationship with head of family: ___________

c. Age_____

d. Religion_____

e. Education___________

f. Occupation____

g. Monthly income________

h. Gender: Male/Female _________

i. Marital Status _____________

j. Address_________

k. Contact No._______

**Format for various activities to be carried out at Special Clinics – NCD Clinics**

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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
Activity 4: Organizing and Conducting Special Clinics  (PHC -2)

**Identification Data:**

a. Name _______

b. Relationship with head of family: ____________

c. Age______  
d. Religion______

e. Education ______________  
f. Occupation_______

g. Monthly income ____________  
h. Gender : Male/Female _________

i. Marital Status ____________  
j. Address__________  
k. Contact No.__________

Format for various activities to be carried out at Special Clinics – NCD Clinics

<table>
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<tr>
<th>Health Facility</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
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Activity 4: Organizing and Conducting Special Clinics  

**Identification Data:**
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- c. Age______
- d. Religion______
- e. Education____________
- f. Occupation______
- g. Monthly income________
- h. Gender : Male/Female _______
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

D. Format for various activities to be carried out at Special Clinics – NCD Clinics

<table>
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<tr>
<th>Health Facility</th>
<th>Services</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 4: Organizing and Conducting Special Clinics  (SC-2)

**Identification Data:**

a. Name _______

b. Relationship with head of family: ____________

c. Age________

d. Religion_______

e. Education ____________

f. Occupation______

g. Monthly income ____________

h. Gender :Male/Female ____________

i. Marital Status ____________

j. Address_________

k. Contact No._______

E. Format for various activities to be carried out at Special Clinics – NCD Clinics

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Services</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 5: Investigation of an Outbreak

Guidelines:
Follow the steps of investigation of an epidemic / disease outbreak in your area as per guidelines given in the BNSL-043

- identify and estimate the number of cases affected
- prepare epidemic curve of the disease outbreak
- fill up epidemiological case sheet as per the example given in logbook below
- prepare report of the epidemic occurrence
- check the available records if required to fill up the epidemiological case sheet.

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _________ Registration No. _________

Identification Data:

a. Name ______
b. Relationship with head of family: _____________
c. Age ______
d. Religion ______
e. Education _____________
f. Occupation ______
g. Monthly income ______
h. Gender: Male/Female ______
i. Marital Status __________
j. Address ______
k. Contact No. ______

Investigation of an outbreak

<table>
<thead>
<tr>
<th>Steps</th>
<th>Findings and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure existence of outbreak</td>
<td></td>
</tr>
<tr>
<td>Confirm Diagnosis with the help of authorised health professional</td>
<td></td>
</tr>
<tr>
<td>Estimate the Number of Cases</td>
<td></td>
</tr>
<tr>
<td>Analyse the data in terms of Time, Place and Person</td>
<td></td>
</tr>
<tr>
<td>Determine who is at risk of contracting the disease</td>
<td></td>
</tr>
</tbody>
</table>
Epidemiological Case Sheet

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Details</th>
<th>Findings</th>
<th>Management/Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identification No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Date and time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Address: Residence, workplace separately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Contact no:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Symptoms present, Date and time of onset:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Source of water supply- Tap/ hand pump/ well/ river/ ponds/ natural water body/ etc. History of travel outside/ History of intake of food items outside house, items taken/Any medication taken and names/Any laboratory investigations: check and note based on available records/Family members list with age, sex, any family member suffering from the infection, their onset day and time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
### Activity 5: Investigation of an Outbreak (PSC/DH-2)

**Name of the Health Facility**: _____________________  **Date**: ____________

**Date of Registration**: _______  **Registration No.**: ________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: __________
- c. Age _______
- d. Religion _______
- e. Education __________
- f. Occupation _______
- g. Monthly income __________
- h. Gender: Male/Female _______
- i. Marital Status __________
- j. Address __________
- k. Contact No. _______

#### Investigation of an outbreak

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<tr>
<td>Estimate the Number of Cases</td>
<td></td>
</tr>
<tr>
<td>Analyse the data in terms of Time, Place and Person</td>
<td></td>
</tr>
<tr>
<td>Determine who is at risk of contracting the disease</td>
<td></td>
</tr>
<tr>
<td>Prepare Written Report</td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor / Supervisor**
## Activity 5: Investigation of an Outbreak (CHC-1)

Name of the Health Facility __________________ Date: _____________

Date of Registration: _______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: __________
- c. Age _______
- d. Religion _______
- e. Education ____________
- f. Occupation _______
- g. Monthly income _______
- h. Gender : Male/Female _______
- i. Marital Status _______
- j. Address _______
- k. Contact No. _______

### Investigation of an outbreak

<table>
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<tr>
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<tr>
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**(Attached additional sheets if required)**

Signature of the Academic Counselor / Supervisor
### Activity 5: Investigation of an Outbreak (CHC-2)

Name of the Health Facility _____________________ Date: ____________

Date of Registration: _______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: ____________
- c. Age_____ d. Religion_____
- e. Education ____________ f. Occupation_______
- g. Monthly income ____________ h. Gender : Male/Female _______
- i. Marital Status ____________ j. Address_________
- k. Contact No.______

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Signature of the Academic Counselor / Supervisor
Activity 5: Investigation of an Outbreak (PHC-1)

Name of the Health Facility _____________________ Date: _______________  
Date of Registration: _______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: _______________
  c. Age_______ d. Religion_______  
  e. Education _______________ f. Occupation_______  
  g. Monthly income ___________ h. Gender : Male/Female __________  
  i. Marital Status ___________ j. Address_________  
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Investigation of an outbreak

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Signature of the Academic Counselor /Supervisor
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- f. Occupation __________
- g. Monthly income __________
- h. Gender: Male/Female __________
- i. Marital Status __________
- j. Address __________
- k. Contact No. ________

**Investigation of an outbreak**

<table>
<thead>
<tr>
<th>Steps</th>
<th>Findings and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure existence of outbreak</td>
<td></td>
</tr>
<tr>
<td>Confirm Diagnosis with the help of authorised health professional</td>
<td></td>
</tr>
<tr>
<td>Estimate the Number of Cases</td>
<td></td>
</tr>
<tr>
<td>Analyse the data in terms of Time, Place and Person</td>
<td></td>
</tr>
<tr>
<td>Determine who is at risk of contracting the disease</td>
<td></td>
</tr>
<tr>
<td>Prepare Written Report</td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
**Activity 5 : Investigation of an Outbreak**  

**Identification Data:**
- a. Name __________
- b. Relationship with head of family: __________
- c. Age __________
- d. Religion __________
- e. Education __________
- f. Occupation __________
- g. Monthly income __________
- h. Gender: Male / Female __________
- i. Marital Status __________
- j. Address __________
- k. Contact No. __________

## Investigation of an outbreak

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(Attach additional sheets if required)  

Signature of the Academic Counselor / Supervisor
### Activity 5: Investigation of an Outbreak (SC-2)

<table>
<thead>
<tr>
<th>Name of the Health Facility</th>
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</tr>
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<tbody>
<tr>
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**Identification Data:**
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### Investigation of an outbreak

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(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 6: Identification and appropriate management of communicable diseases (PSC/DH-1)

- Select two patients / cases for identifying communicable diseases
- Take history of the patient
- Assess signs and symptoms indicating any communicable disease
- Identify the problems based on signs and symptoms
- Take the action as per guidelines in practical manual
- Record the findings

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. __________

Identification Data:
  a. Name _______
  b. Relationship with head of family: ____________
  c. Age _______
  d. Religion _______
  e. Education ____________
  f. Occupation _______
  g. Monthly income _______
  h. Gender: Male/Female _______
  i. Marital Status ___________
  j. Address ___________
  k. Contact No. _______

Guidelines for Assessment | Findings | Management / Referral
---|---|---
History of present illness | | |
History of past medical illness | | |
Family h/o medical illness | | |
**Malaria:**
attacks of fever, every 3rd or 4th day with three stages:
**Cold Stage:**
Headache/nausea/vomiting/chills with rigors.
**Hot Stage:**
Headache worsens and temperature is very hot, lasts for 2-6 hours.
**Sweating Stage:**
temperature drops down to normal with profuse sweating/jaundice/anemia

**Kalazar:**

Refer:
BNS-041
Block: 3
Unit: 1-4
BNSL-043
Block: 3
Unit: 2
Fever/Splenomegaly and hepatomegaly/Aneamia/Weight loss  
Darkening of skin of face, hands, feet and abdomen/Lymphadenopathy  
Multiple nodular infiltration of skin usually without ulceration/ painful ulcers in part of body exposed to sand fly.

Japanese Encephalitis (JE):  
viral infection presents classical symptoms similar to any other viral encephalitis/fever (38-41°C), headache/meningitis or encephalitis. Severe rigors/stupor/disorientation/coma/tremors/paralysis (generalized/hypertonia) loss of coordination etc.

Dengue Fever:  
Assess for Flu-like symptoms which lasts for 2-7 days.  
High Fever (40°C/104°F) is usually accompanied by at least two of the following symptoms:  
- Headaches  
- Pain behind eyes  
- Nausea, vomiting  
- Swollen glands  
- Joint, bone or muscle pains  
- Rash

(Attach additional sheets if required)

Guidelines for selected diseases have been given you may record if required.

Signature of the Academic Counselor/Supervisor
Activity 6: Identification and appropriate management of communicable diseases  
(PSC/DH-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _________
c. Age________ d. Religion_______
e. Education_____________ f. Occupation_______
g. Monthly income _________ h. Gender :Male/Female _________
i Marital Status __________ j. Address________
j. Gender :Male/Female _________
k. Contact No.________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 6: Identification and appropriate management of communicable diseases

Name of the Health Facility _____________________ Date: ________________
Date of Registration: ______ Registration No. ______

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Signature of the Academic Counselor/Supervisor
Activity 6: Identification and appropriate management of communicable diseases (CHC-2)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: ____________
   c. Age______
   d. Religion______
   e. Education______________
   f. Occupation______
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   j. Address_________
   k. Contact No._______

Guidelines for Assessment | Findings | Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 6: Identification and appropriate management of communicable diseases (PHC-1)

| Name of the Health Facility: ___________________ Date: ______________ |
| Date of Registration: _______ Registration No. ________ |

#### Identification Data:
- **a.** Name: ___________
- **b.** Relationship with head of family: ___________
- **c.** Age: _______
- **d.** Religion: _______
- **e.** Education: ___________
- **f.** Occupation: ___________
- **g.** Monthly income: _______
- **h.** Gender: Male/Female: ___________
- **i.** Marital Status: ___________
- **j.** Address: ___________
- **k.** Contact No. _______

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Signature of the Academic Counselor/Supervisor
Activity 6: Identification and appropriate management of communicable
diseases (PHC-2)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
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**Signature of the Academic Counselor/Supervisor**
Activity 6: Identification and appropriate management of communicable diseases  

Name of the Health Facility _____________________ Date: ________________

Date of Registration: _______  Registration No. _______

Identification Data:

a. Name ______
b. Relationship with head of family: __________
c. Age ______
d. Religion ______
e. Education __________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 6: Identification and appropriate management of communicable diseases  

SC-2

Name of the Health Facility _____________________ Date: ________________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______

b. Relationship with head of family: ________________

c. Age______

d. Religion_______

e. Education____________

f. Occupation_____

g. Monthly income ___________

h. Gender :Male/Female ____________

i. Marital Status _____________

j. Address_________

k. Contact No._______

Guidelines for Assessment | Findings | Management / Referral
---|---|---

(Activity additional sheets if required)

Signature of the Academic Counselor/Supervisor
## Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD) (PSC/DH-1)

- select two patients for identification of NCD
- fill up the community based check list for early identification of NCD as per format given
- assess the risk status for NCD using the check list
- identify signs and symptoms for early detection of NCD as per the format given
- do the detailed assessment of each NCD
- take appropriate action
- record the findings in appropriate column

**Name of the Health Facility as given below** ____________________________ **Date:** ____________

**Date of Registration:** _______ **Registration No.** __________

### Identification Data:
- a. Name _______
- b. Relationship with head of family: ___________
- c. Age _______  
- e. Education ___________
- g. Monthly income ___________
- i. Marital Status ___________
- d. Religion _______
- f. Occupation _______
- h. Gender: Male/Female _______
- j. Address ___________
- k. Contact No. _______

### Format for Risk Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Range</th>
<th>Finding</th>
<th>Write Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your age? (in complete years)</td>
<td>30-39 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40-49 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥ 50 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do u smoke or consume smokeless products such as Gutka; or Khaini?</td>
<td>Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Used to consume in the past/sometimes now</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you consume Alcohol daily?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Measurement (Abdominal girth)

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 80 cm</td>
<td>&lt; 90 cm</td>
</tr>
<tr>
<td>80-90 cm</td>
<td>90-100 cm</td>
</tr>
<tr>
<td>&gt;90 cm</td>
<td>&gt;100 cm</td>
</tr>
</tbody>
</table>

5. Do you undertake any physical activities for minimum of 150 minutes in a week?

| Less than 150 minutes in a week | At least 150 minutes in a week |

6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?

| No | Yes |

**Total Score**

A score above 4 indicates that the person may be at risk for these NCDs and needs to be prioritized for attending the weekly NCD day.

**Part B: Early Detection of NCD:**

**Women and Men**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td></td>
</tr>
<tr>
<td>Coughing more than 2 weeks</td>
<td></td>
</tr>
<tr>
<td>Blood in sputum</td>
<td></td>
</tr>
<tr>
<td>History of fits</td>
<td></td>
</tr>
<tr>
<td>Difficulty in opening mouth</td>
<td></td>
</tr>
<tr>
<td>Ulcers/patch/growth in the mouth that has not healed in two weeks</td>
<td></td>
</tr>
<tr>
<td>Any change in the tone of your voice</td>
<td></td>
</tr>
</tbody>
</table>

**Women only**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lump in the breast</td>
<td></td>
</tr>
<tr>
<td>Blood stained discharge from the nipple</td>
<td></td>
</tr>
<tr>
<td>Change in shape and size of breast</td>
<td></td>
</tr>
<tr>
<td>Bleeding between periods</td>
<td></td>
</tr>
<tr>
<td>Bleeding after menopause</td>
<td></td>
</tr>
<tr>
<td>Bleeding after intercourse</td>
<td></td>
</tr>
<tr>
<td>Foul smelling vaginal discharge</td>
<td></td>
</tr>
</tbody>
</table>

In case the individual answers yes to any one of the above mentioned symptoms, refer the patient immediately to the nearest facility where a Medical officer is available.

**Format for Assessment and Management of NCDs**

<table>
<thead>
<tr>
<th>NCDs</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardio Vascular Disease (CVD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coronary heart disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain (angina) Sub sternal pressure radiating to neck, jaw, arm with duration &lt;20-30 minutes which may be associated with dyspnea/ palpitations, nausea vomiting.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Mayocardial Infection (MI):** Has angina increased intensity and duration >30 min. Associated symptoms: Weakness/nausea/vomiting, sweating/apprehension/anxiety/sense of impending doom.

**Stroke**
Sudden onset of the following:
- weakness of one half of body or one part of body
- inability or difficulty in speech
- imbalance
- blindness
- dizziness or spinning
- severe headache
- Seizures
- loss of consciousness

**Diabetes**
- age of or above 30 years
- overweight (BMI is more than 23kg/m2).
- physically inactive (exercises less than 3 times a week)
- high blood pressure.
- impaired fasting glucose or impaired glucose tolerance.
- parents/siblings or grandparents have or had diabetes.
- had diabetes or even mild elevation of blood sugars during pregnancy.

**uncontrolled hyperglycemia**
excess thirst/ excess urination/ excess hunger with loss of weight / Frequent infections/ Non-healing wounds

Raised BMI is a major risk factor for non-communicable diseases such as heart disease, stroke, diabetes; osteoarthritis cancers (including endometrial, breast, ovarian, prostate, liver, gallbladder, kidney, and colon).

**Signature of the Academic Counselor/Supervisor**
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD) (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
- d. Religion_______
- e. Education _____________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female _________
- i. Marital Status ____________
- j. Address_________
- k. Contact No._________

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Signature of the Academic Counselor/Supervisor
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD) (CHC-1)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
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Signature of the Academic Counselor/Supervisor
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)  
(CHC-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
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Signature of the Academic Counselor/Supervisor
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)-

Name of the Health Facility as given below ________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______
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Signature of the Academic Counselor/Supervisor
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD) - (PHC-2)

Name of the Health Facility as given below _____________________ Date:________________

Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
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Signature of the Academic Counselor/Supervisor
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)- (SC-1)

Name of the Health Facility as given below _____________________ Date:____________

Date of Registration:_______ Registration No.________

Identification Data:
   a. Name ________
   b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
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Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)- (SC-2)

Name of the Health Facility as given below ___________________________ Date: ________________

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Identification Data:
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(Attach additional sheets if required)
Activity 8: Social Mobilization Skills (PSC/DH-1)

- visit the selected community
- identify the problems
- write down the process of social mobilization adopted
- prepare the report

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age____
- d. Religion____
- e. Education ______________
- f. Occupation____
- g. Monthly income _________
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Refer:
Block: 1
Unit: 5
BNSL-043
| Identify general and specific problems of the community |  |
| Creating awareness about problem |  |
| Preparation of awareness material |  |
| Community participation and responsibility / ownership in planning and implementing the programme |  |
| Empowerment of Community |  |

(Activity 8: Social Mobilization Skills (PSC/DH-2))

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
- d. Religion_______
- e. Education ____________
- f. Occupation_______
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</thead>
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(Attach additional sheets if required)  

Signature of the Academic Counselor/ Supervisor
Activity 8: Social Mobilization Skills (CHC-1)

Identification Data:

a. Name __________
b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
c. Age______
d. Religion_______
e. Education___________
f. Occupation______
g. Monthly income________
h. Gender :Male/Female __________
i. Marital Status ____________
j. Address________
k. Contact No.________
### Activity 8: Social Mobilization Skills (CHC -2)

**Identification Data:**
- a. \( \text{Name} \)
- b. Relationship with head of family: Self/Wife/son/daughter/any other
- c. Age
- d. Religion
- e. Education
- f. Occupation
- g. Monthly income
- h. Gender: Male/Female
- i. Marital Status
- j. Address
- k. Contact No.

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Findings</th>
<th>Management and Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Findings</th>
<th>Management and Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor/ Supervisor**

**Activity 8: Social Mobilization Skills (PHC-1)**

**Identification Data:**

- **a. Name ______**
- **b. Relationship with head of family: Self/Wife/son/daughter/any other __________**
- **c. Age_______**
- **d. Religion_______**
- **e. Education __________**
- **f. Occupation______**
- **g. Monthly income________**
- **h. Gender : Male/Female __________**
- **i. Marital Status __________**
- **j. Address________**
- **k. Contact No._______**
### Activity 8: Social Mobilization Skills (PHC-2)

#### Identification Data:

- **a.** Name ________
- **b.** Relationship with head of family: Self/Wife/son/daughter/any other __________
- **c.** Age ________
- **d.** Religion ________
- **e.** Education __________
- **f.** Occupation ________
- **g.** Monthly income __________
- **h.** Gender: Male/Female __________
- **i.** Marital Status __________
- **j.** Address __________
- **k.** Contact No. __________

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<thead>
<tr>
<th>Guidelines</th>
<th>Findings</th>
<th>Management and Referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Findings</th>
<th>Management and Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

**Activity 8: Social Mobilization Skills** *(SC-2)*

**Identification Data:**
- a. Name ________
- b. Relationship with head of family: Self/Wife/son/daughter/any other __________
- c. Age ________
- d. Religion ________
- e. Education __________
- f. Occupation ________
- g. Monthly income ________
- h. Gender : Male/Female ________
- i. Marital Status ________
- j. Address ________
- k. Contact No. ________
# Activity 8: Social Mobilization Skills (SC-2)

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other __________
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation_______
- g. Monthly income_________
- h. Gender: Male/Female_________
- i. Marital Status __________
- j. Address_________
- k. Contact No._________

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
### Activity 9: Health Education/Counselling (PSC/DH-1)

Select following groups:
- Adults (Female/Male)
- School Children
- Under 5 children and their mothers

Prepare a plan of health education as per the need.

---

(Attach additional sheets if required)

---

Signature of the Academic Counselor/Supervisor

---

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Findings</th>
<th>Management and Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Conduct health education / counseling sessions

Record the process in your logbook

**Name of the Health Facility – District Hospital  Date : ______________**

**Outline of Health Teaching /Counseling Plan**

Topic covered

Type of Group Adults/School Children/

Number of group members

Place

Time

Duration _____________ to ______________

Persons or Health worker involved

Supervisor

Previous Experience or knowledge of the Group: Ask the ground and record

**Teaching Plan**

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

**Activity 9: Health Education/Counselling (PSC/DH-2)**

**Name of the Health Facility – District Hospital**  **Date**: __________

**Outline of Health Teaching /Counseling Plan**

- **Topic covered**
- **Type of Group**: Adults/School Children/
- **Number of group members**
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Activity 9: Health Education/Counselling (CHC-1))

Name of the Health Facility – District Hospital  Date : ______________

Outline of Health Teaching /Counseling Plan

Topic covered

Type of Group Adults/School Children/
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)  
Signature of the Academic Counselor /Supervisor

**Activity 9: Health Education/Counselling (CHC-2)**

Name of the Health Facility – District Hospital  Date : ____________

Outline of Health Teaching /Counseling Plan

Topic covered
Type of Group Adults/School Children/
Number of group members
Place
Time
Duration _____________ to ______________

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 9: Health Education/Counselling (PHC-1)

Name of the Health Facility – District Hospital Date: ____________

Outline of Health Teaching/Counseling Plan

Topic covered

Type of Group Adults/School Children/

Number of group members

Place

Time Duration _____________ to ______________

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 9: Health Education/Counselling (PHC-2)

Name of the Health Facility – District Hospital Date: ____________

Outline of Health Teaching /Counseling Plan

Topic covered
Type of Group Adults/School Children/
Number of group members
Place
Time Duration _____________ to ______________

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 9: Health Education/Counselling (SC-1)

Name of the Health Facility – District Hospital  Date: ______________

Outline of Health Teaching/Counseling Plan

Topic covered

Type of Group Adults/School Children/

Number of group members

Place

Time  Duration _____________ to ______________

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
### Activity 9: Health Education/Counselling

Name of the Health Facility – District Hospital   Date : _____________

**Outline of Health Teaching/Counseling Plan**

- Topic covered
- Type of Group Adults/School Children/
- Number of group members
- Place
- Time
  Duration _____________ to ______________

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content</th>
<th>Teaching Learning Activity</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor /Supervisor**
Activity 10: Recording and Reporting Format

- Visit a health facility
- Observe the records and registers maintained for various activities
- Document your findings after completing the activity (such as household survey etc.) in the formats given below.

Map of the Community

Guidelines:
Identify the village to be covered for preparing map
Draw the map, mark community resources etc. as explained in Section 7.2.1.
Also read BNS-041 Block 3 Unit 3.

Name of the Health Centre ________________________ Date : ________________

Draw Map in the space given
## Village Register

<table>
<thead>
<tr>
<th>S. No</th>
<th>Content/steps</th>
<th>Findings and Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of households</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The population of each village.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The population distribution according to age and sex.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Number of Anganwadi centres with the name and address of AWWs.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of private practitioners (Allopathic, Ayurvedic, Homeopathic, RMP etc).</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dais in each village (name and address).</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Schools – location.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Panchayat Bhawan – Name and address of the Sarpanch.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>M.S.S/Mahila Mandal members.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Voluntary organizations, if any.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Number of deep hand-pumps</td>
<td></td>
</tr>
</tbody>
</table>

Signature of the Academic Counselor/Supervisor
<table>
<thead>
<tr>
<th>S.No</th>
<th>Content/steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of eligible couples (ECs).</td>
</tr>
<tr>
<td>2</td>
<td>Number of pregnant mothers.</td>
</tr>
<tr>
<td>3</td>
<td>Number of pregnant mothers registered.</td>
</tr>
<tr>
<td>4</td>
<td>Number of pregnant mothers registered given full doses of TT.</td>
</tr>
<tr>
<td>5</td>
<td>Number of births.</td>
</tr>
<tr>
<td>6</td>
<td>Number of births registered.</td>
</tr>
<tr>
<td>7</td>
<td>Number of home deliveries.</td>
</tr>
<tr>
<td>8</td>
<td>Number of home deliveries conducted by TBAs.</td>
</tr>
<tr>
<td>9</td>
<td>Number of home deliveries conducted by ANM/ LHV.</td>
</tr>
<tr>
<td>10</td>
<td>Number of deliveries conducted at PHCs/CHCs/ Govt. hospitals/nursing homes.</td>
</tr>
<tr>
<td>11</td>
<td>Number of deliveries conducted by private practitioners.</td>
</tr>
<tr>
<td>12</td>
<td>Number of pregnant mothers referred as high risk cases.</td>
</tr>
<tr>
<td>13</td>
<td>Number of pregnant mothers who develop any kind of complication.</td>
</tr>
<tr>
<td>14</td>
<td>Number of abnormal deliveries.</td>
</tr>
<tr>
<td>15</td>
<td>Number of abortions.</td>
</tr>
<tr>
<td>16</td>
<td>Number of low birth weight babies born.</td>
</tr>
<tr>
<td>17</td>
<td>Number of newborns who had difficulty in breathing immediately after birth (did not cry immediately).</td>
</tr>
<tr>
<td>18</td>
<td>Number of neonatal deaths occurred.</td>
</tr>
<tr>
<td>19</td>
<td>Any stillborn baby delivered.</td>
</tr>
<tr>
<td>20</td>
<td>Number of children upto one year of age.</td>
</tr>
<tr>
<td>21</td>
<td>Number of children below 3 years of age.</td>
</tr>
<tr>
<td>22</td>
<td>Number of children below 5 years of age.</td>
</tr>
<tr>
<td>23</td>
<td>Number of children who have had frequent episode of diarrhea.</td>
</tr>
<tr>
<td>24</td>
<td>Any children referred due to dehydration.</td>
</tr>
<tr>
<td>25</td>
<td>Number of children who have had frequent attacks of ARI.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>Number of children referred to PHC/hospital for treatment of pneumonia.</td>
</tr>
<tr>
<td>27</td>
<td>Number of children suffering from malnutrition.</td>
</tr>
<tr>
<td>28</td>
<td>Number of children going to AW centre.</td>
</tr>
<tr>
<td>29</td>
<td>Number of children completely or fully immunized.</td>
</tr>
<tr>
<td></td>
<td>0-1 year</td>
</tr>
<tr>
<td></td>
<td>upto 3 years</td>
</tr>
<tr>
<td></td>
<td>upto 5 years</td>
</tr>
<tr>
<td>30</td>
<td>Number of women using oral pills. Women who have undergone MTP.</td>
</tr>
<tr>
<td>31</td>
<td>Number of women who got Cu “T” inserted.</td>
</tr>
<tr>
<td>32</td>
<td>Number of couples using condom.</td>
</tr>
<tr>
<td>33</td>
<td>Number of women who had accepted sterilization (tubectomy).</td>
</tr>
<tr>
<td>34</td>
<td>Number of men who have undergone vasectomy.</td>
</tr>
<tr>
<td>35</td>
<td>Number of women who are having signs and symptoms of RTI/STI.</td>
</tr>
<tr>
<td>36</td>
<td>Number of women/couples taking any treatment for RTI/STI.</td>
</tr>
<tr>
<td>37</td>
<td>Number of adolescents –</td>
</tr>
<tr>
<td></td>
<td>(i) Girls (10-19 years)</td>
</tr>
<tr>
<td></td>
<td>(ii) Boys (10-19 years)</td>
</tr>
</tbody>
</table>

Signature of the Academic Counselor/Supervisor
## Eligible Couple Register

<table>
<thead>
<tr>
<th>S.No</th>
<th>Content/steps</th>
<th>Findings and Remarks</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify number of couples</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Parity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Age of youngest child</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Contraceptive method used</td>
<td></td>
</tr>
</tbody>
</table>

Signature of the Academic Counselor/Supervisor

Refer:  
Block: 1  
Unit: 7/Sec 7.2.4  
BNSL-043
Cumulative Family Folder/Record

Family Folder

1. Name of Head of Family (HoF) 
   ________________

2. House No. 
   ________________

3. Family Unique ID 
   ________________

4. Type of Family (joint or nuclear) 
   ________________

5. Religion 
   ________________

6. Caste 
   ________________

7. Below Poverty Line B.P.L (Y/N) 
   ________________

8. Details of family members

<table>
<thead>
<tr>
<th>Name of family member</th>
<th>Age / Sex</th>
<th>Rel. with HoF</th>
<th>Age at marriage</th>
<th>Edn</th>
<th>Occupation</th>
<th>Income</th>
<th>Ht</th>
<th>Wt</th>
<th>Any health problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

9. Birth and Death data

   a) Any birth in last 12 months (Y/N) 
      ________________

      i) Number 
      ________________

      ii) Sex 
      ________________

   b) Any death in last 12 months (Y/N) 
      ________________

      i) Number 
      ________________

      ii) Sex 
      ________________

10. Communication facility available (Y/N) 

    a) Newspaper 
    ________________

    b) Phone 
    ________________

    c) TV/Radio 
    ________________

    d) Other (specify) 
    ________________
11. Social Abnormalities

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unique ID</th>
</tr>
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<tr>
<td>Addiction</td>
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</tr>
<tr>
<td>Widow</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Delinquent behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Environment

a) Type of House
   Pukka /Kuchha / Semi Pukka

b) Total living area/sq feet

c) Type of toilet
   Attached/ Semi Attached/Detached

d) Electricity supply (Y/N)

e) Ventilation: Adequate / Not Adequate

f) Lighting: Adequate / Not Adequate

g) Source of water supply: Tap/Bore/other

h) Water Storage : Safe/Unsafe

i) Waste Water Drainage: Sewerage/Drain/soak pit/open

j) Refuse : open field/ Municipal Van

k) Sanitary latrine : Yes/No

l) Pet Animal : Yes / No
   If Yes, Pet is kept Inside House / Outside House

13. Family Planning (ask in case of eligible couple in the family).

<table>
<thead>
<tr>
<th>Contraceptive method used</th>
<th>Unique ID of EC</th>
<th>Duration of use</th>
<th>Satisfied</th>
<th>Not satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td></td>
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<tr>
<td>OCP</td>
<td></td>
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</tr>
</tbody>
</table>
Antenatal Records

1. Unique ID No of woman __________________
2. Name of the antenatal mother __________________
3. Husbands name __________________
4. Residential address __________________
5. Age (yrs) __________________
6. L.M.P __________________
7. E.D.D __________________
8. MAMTA Card Present(Y/N) __________________
9. Gestational age at registration __________________
10. No. of ANC visits done __________________
11. Lab Investigations (ask and record) 
   a) Hb __________________
   b) Urine Sugar/Albumin __________________
   c) Blood grouping /typing __________________
12. Tetanus Toxoid Vaccine
   a) I Dose __________________
   b) II Dose __________________
   c) Booster __________________
13. Any disease during Pregnancy (Anaemia/H.T/Any other specify) __________________
14. Treatment taken __________________

Natal Records

1. Place of Delivery (Institutional/Home) __________________
2. Delivery conducted by
   TBA/Untrained TBA/ ANM /LHV/Community Health Nurse /Doctor __________________
3. Any complications during delivery (Y/N) __________________
   If yes specify__________________________

Post Natal Records
1. No. of days in hospital __________________
2. No. of visits for post natal check up __________________
3. Any complication (Y/N) __________________
   If yes specify ________________________________
4. Initiation of Breast Feeding __________________

**Contraception Register**

1. Temporary method
   a) Female: Oral Pills / IUD/ any other ________________
   b) Male : Nirodh/ any other ________________
2. Permanent Method
   Vasectomy for male / Tubectomy for female ________________

**Child Health Register (Under Five Years)**

1. Unique ID of child __________________
2. Name of the child __________________
3. Fathers name __________________
4. Mothers name __________________
5. Age / Sex __________________
6. Date of Birth __________________
7. Birth weight (Kg) __________________
8. Place of birth (Institutional/home) __________________
9. Initiation of Breast feeding __________________
10. Exclusive breast feeding till age (in months) __________________
11. Age of weaning __________________
12. Immunization Card (Y/N) __________________
13. BCG __________________
14. HEP (birth dose) __________________
15. OPV (Zero dose) __________________
16. Penta 1/OPV 1 __________________
17. Penta 2/OPV 2 __________________
18. Penta 3/OPV 3 __________________
19. Measles 1 ____________________
20. Vit A OPV/DPTB Mesales 2 ____________________
21. DPT 2nd ____________________

Signature of the Academic Counselor/Supervisor

Sub-Centre/FRU Clinic Register

<table>
<thead>
<tr>
<th>S.No</th>
<th>Date</th>
<th>Name &amp; Address</th>
<th>Complaints</th>
<th>Medicine given</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Signature of the Academic Counselor/Supervisor
## Death Register

<table>
<thead>
<tr>
<th>S.No</th>
<th>Date of death</th>
<th>Name and address</th>
<th>Age</th>
<th>Sex</th>
<th>Cause of death</th>
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</table>

Signature of the Academic Counselor/Supervisor
## Stock Register

### Drugs:

<table>
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<tr>
<th>Date</th>
<th>Previous balance</th>
<th>Quantity received</th>
<th>Quantity used</th>
<th>Balance in hand</th>
<th>Expiry Date</th>
<th>Remarks</th>
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### Inventory of Vaccines and Drugs

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<tr>
<th>S. No</th>
<th>Item</th>
<th>Unit</th>
<th>Requirement assessed last year</th>
<th>Actual quantity received last year</th>
<th>Surplus of shortage last year</th>
<th>Requirement for current year</th>
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<tr>
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<td>Cotrimoxazole</td>
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<td>(Disposable Delivery Kits)</td>
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## Monthly Stock Position

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<th>Balance</th>
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<td>Cotrimoxozole</td>
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### Vaccine Received from PHC

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<tr>
<th>S. No</th>
<th>Name of vaccine weekly session 1 Date/dose</th>
<th>Vaccine received for weekly session 1 Date/dose</th>
<th>Vaccine received for weekly session 2 Date/dose</th>
<th>Vaccine received for weekly session 3 Date/dose</th>
<th>Vaccine received for weekly session 4 Date/dose</th>
<th>Vaccine received for weekly</th>
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Signature of the Academic Counselor/Supervisor
Register for Recording Consultative Process

<table>
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<tr>
<th>Month/Year</th>
<th>Date &amp; Time of holding the meeting</th>
<th>Venue/Place</th>
<th>Members who attended meeting</th>
<th>Items discussed</th>
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<td>7.</td>
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Signature of the Academic Counselor/Supervisor
## Referral Register

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<th>Name &amp; Address</th>
<th>Age</th>
<th>Sex</th>
<th>Complaints</th>
<th>Reasons for Referral</th>
<th>Referred to</th>
<th>Follow-up actions taken</th>
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</tbody>
</table>

Signature of the Academic Counselor/Supervisor
Live Birth Report

Serial No _________

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

Town/Municipality ____________________________________________

1. Date of Birth:
2. Sex – Male/Female
3. Name of Child
4. Place of Birth
5. Permanent residential address
6. Father’s
   • Name
   • Literacy
   • Occupation
   • Religion
7. Mother’s
   • Name
   • Literacy
   • Occupation
   • Religion
8. Age of mother in completed years at confinement
9. Order of birth
   (Number of live births including birth registered)
10. Type of attention at delivery
11. Informant’s
   • Name
   • Address

Date__________________                     Signature or thumb mark of the informant
Still Birth Report

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

Town/Municipality ________________________________

1. Date of Birth:
2. Sex – Male/Female
3. Place of Birth*
4. Permanent residential address
5. Father’s
   • Name
   • Literacy
   • Occupation
   • Religion

6. Mother’s
   • Name
   • Literacy
   • Occupation
   • Religion

7. Age of mother in completed years at confinement
8. Type of attention at delivery+
9. Informant’s
   • Name
   • Address

Date__________________ Signature or thumb mark of the informant

Refer:
Block: 1
Unit: 7/Sec 7.2.12
BNSL-043
Death Report

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

______________________________

1. Date of death
2. Full name of the deceased
3. Place of death
4. Name of the father/husband
5. Age
6. Sex – Male/Female
7. Marital Status
8. Occupation
9. Religion
10. Nationality
11. Permanent residential address+
12. Cause of death*
13. Whether medically certified (Yes/No)
14. Kind of medical attention received, if any
15. Informant’s
   i) Name
   ii) Address

Date__________________________  Signature /thumb mark of the informant
**Monthly Report for Sub-centre**

**General Information**

1. State: _______________________________________________________________
2. District: _____________________________________________________________
3. PHC: _______________________________________________________________
4. Sub-centre: _________________________________________________________
5. Population of PHC: _________________________________________________
6. Population of sub-centre: _____________________________________________
7. Reporting for the month of: ___________________________________________
8. Eligible couples (as on 1st April of the year): ____________________________

<table>
<thead>
<tr>
<th>S. No</th>
<th>Services</th>
<th>Performance in corresponding month of last year</th>
<th>Performance in the reporting month</th>
<th>Cumulative performance till corresponding month of last year</th>
<th>Cumulative performance till current month</th>
<th>Planned performance in current month</th>
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<td>Antenatal Care</td>
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<td>Antenatal Cases registered</td>
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<tr>
<td></td>
<td>a) Total</td>
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<tr>
<td></td>
<td>b) &lt; 12 weeks</td>
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<td>No. of pregnant women who had 3 check-ups</td>
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<td>Total no. of high risk pregnant women referred</td>
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<td>ii) TT 2</td>
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<td>iii) Booster</td>
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<td>No. of pregnant women under treatment for anaemia</td>
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<td>women given prophylaxis for anaemia</td>
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<tr>
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<td>2.1</td>
<td>Total No. of deliveries</td>
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</tbody>
</table>
| 2.2 | Home Deliveries  
(a) by ANM  
(ii) by LHV  
(b) by TBA  
c) Untrained Birth Attendant |   |   |   |
| 2.3 | Deliveries at sub-centre |   |   |   |
| 2.4 | Complicated deliveries referred to PHC/FRU |   |   |   |
| 3 | Maternal Deaths |   |   |   |
| 3.1 | During pregnancy |   |   |   |
| 3.2 | During delivery |   |   |   |
| 3.3 | Within 5 weeks of delivery |   |   |   |
| 4 | Post Natal Care |   |   |   |
| 4.1 | No of women given 3 post natal check-ups |   |   |   |
| 4.2 | Complications referred to PHC/FRU |   |   |   |
| 5 | RTI/STI |   |   |   |
| 5.1 | Cases  
(a) Detected  
(b) Treated  
c) Referred |   |   |   |
<p>| 6 | Pregnancy | M | F | M | F | M | F | M | F |</p>
<table>
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<tr>
<th>Outcome</th>
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</thead>
</table>
| 6.1 a) Live births  
b) Still births |  |  |  |  |  |  |  |  |  |  |  |  |
| 6.2 Order of Birth in 3  
a) 1st  
b) 2nd  
c) 3rd |  |  |  |  |  |  |  |  |  |  |  |  |
| 6.3 Newborn status at birth  
a) less than 2.5 kg  
b) 2.5 kg or more  
c) No. of high risk newborns referred to PHC/FRU |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 Immunization | M | F | M | F | M | F | M | F | M | F |  |
| 7.1 Infant 0-1 year  
BCG  
DPT 1  
DPT 2  
DPT 3  
OPV 0  
OPV 1  
OPV 2  
OPV 3  
Measles |  |  |  |  |  |  |  |  |  |  |  |  |
| 7.2 Children more than 18 months  
DPT Booster  
OPV Booster |  |  |  |  |  |  |  |  |  |  |  |  |
| 7.3 Children more than 5 years  
DT |  |  |  |  |  |  |  |  |  |  |  |  |
| 7.4 Children more than 10 years  
TT |  |  |  |  |  |  |  |  |  |  |  |  |
| 7.5 Children more than 16 years  
TT |  |  |  |  |  |  |  |  |  |  |  |  |
| 7.6 Adverse reaction reported after |  |  |  |  |  |  |  |  |  |  |  |  |
### Immunization

<table>
<thead>
<tr>
<th>8</th>
<th>Vitamin A administration (9 months to 3 years)</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>Dose 2</td>
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<tr>
<td></td>
<td>Dose 3-5</td>
<td></td>
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</table>

### Childhood Diseases

<table>
<thead>
<tr>
<th>9</th>
<th>Childhood Diseases</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.1 Vaccine preventable diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Diphtheria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Cases detected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Treated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>iii) Referred</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>iv) Deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Poliomyelitis (AFP)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>i) Cases detected</td>
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<td></td>
<td>ii) Treated</td>
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<td>iii) Referred</td>
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<tr>
<td></td>
<td>iv) Deaths</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>c) Neo Natal Tetanus</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>i) Cases detected</td>
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<td></td>
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<tr>
<td></td>
<td>ii) Treated</td>
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<td></td>
<td>iii) Referred</td>
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<tr>
<td></td>
<td>iv) Deaths</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Measles</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>i) Cases detected</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) Treated</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>iii) Referred</td>
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<tr>
<td></td>
<td>iv) Deaths</td>
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</tr>
<tr>
<td></td>
<td>9.2 ARI under 5 years (Pneumonia)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>a) Treated with Cotrimoxazole</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Referred to PHC/FRU</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Deaths</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### 9.4 Acute Diarrhoeal Diseases under 5 years
- a) Treated with ORS
- b) Referred to PHC/FRU
- c) Deaths

<table>
<thead>
<tr>
<th>10</th>
<th>Child Deaths</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a) Within 1 week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) 1 week - 1 month</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) 1 month – 1 year</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) 1 year – 5 years</td>
<td></td>
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<td></td>
</tr>
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</table>

### 11. Contraceptive Services

#### 11.1 Eligible couples contacted

#### 11.2 Male sterilization
- a) Total no. of cases motivated
- b) No. of cases followed up

#### 11.3 Female sterilization
- a) Total no. of cases motivated
- b) No. of cases followed up

#### 11.4 Total IUD insertion
- a) Cases followed up
- b) Complication
- c) Discontinued
- i) Removed
- ii) Expelled

#### 11.5 Total Oral Pill Users
- a) Old users
- b) New users
- c) Complications
- d) Discontinued
<table>
<thead>
<tr>
<th>Date</th>
<th>Activities performed in the field</th>
<th>Activities performed in the clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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</tbody>
</table>
(Attach additional sheets if required)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
</table>

Signature of the Academic Counselor/ Supervisor
Activity 10: Recording and Reporting Format (CHC)

Name of the Health Centre ________________________ Date: ________________

Draw Map in the space given

Village Register
<table>
<thead>
<tr>
<th>Household Survey Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Couple Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Sub-Centre/FRU Clinic Register

Death Register
Stock Register

Inventory of Vaccines and Drugs
<table>
<thead>
<tr>
<th>Monthly Stock Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Vaccine Received from PHC</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Register for Recording Consultative Process</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Birth Report</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Still Birth Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Death Report</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Monthly Report for Sub-centre</td>
</tr>
<tr>
<td>Daily Diary</td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

[Signature of the Academic Counselor/Supervisor]
Activity 10: Recording and Reporting Format (PHC)

Name of the Health Centre ________________________   Date :  ________________

Draw Map in the space given

Village Register
<table>
<thead>
<tr>
<th>Household Survey Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Couple Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Sub-Centre/FRU Clinic Register</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Death Register</th>
</tr>
</thead>
</table>


Stock Register

Inventory of Vaccines and Drugs
<table>
<thead>
<tr>
<th>Monthly Stock Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine Received from PHC</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>


Register for Recording Consultative Process

Referral Register

156
<table>
<thead>
<tr>
<th>Name of the Health Centre</th>
<th>Date</th>
</tr>
</thead>
</table>

**Draw Map in the space given**

**Village Register**
<table>
<thead>
<tr>
<th>Household Survey Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Couple Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Stock Register</td>
</tr>
</tbody>
</table>

| Inventory of Vaccines and Drugs |
Monthly Stock Position

Vaccine Received from PHC
<table>
<thead>
<tr>
<th>Register for Recording Consultative Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Register</td>
</tr>
</tbody>
</table>
Activity 11: Hand Washing Skills

Follow the steps of hand washing while washing in any health facility as given below:

- Before and after each episode of patient contact
- Between individual patient contacts
- After contact with blood, body fluids, secretions or excretions, whether or not gloves are worn
- After handling soiled/contaminated equipment, materials or the environment
- Immediately after removing gloves or other protective clothing

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age__________

d. Religion__________

e. Education ______________

f. Occupation ______________

g. Monthly income ____________

h. Gender : Male/Female __________

i. Marital Status ______________

j. Address ______________

k. Contact No. _______

act No. _______

**Six steps of hand washing are shown in figure**

- Step1: Palm to palm
- Step2: Back of both hand
- Step3: In between the finger
- Step4: Back of the fingers
- Step5: The thumbs
- Step6: Tip of the fingers

Refer:
BNS: 041
Block :1 Unit : 6
BNSL-043
Block: 2 Unit:1

Signature of the Academic Counselor/ Supervisor
Activity 11: Hand Washing Skills (PSC/DH-2)

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
   c. Age______
   d. Religion_______
   e. Education____________
   f. Occupation_______
   g. Monthly income_________
   h. Gender : Male/Female __________
   i. Marital Status ___________
   j. Address_________
   k. Contact No._________

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 11: Hand Washing Skills (CHC-1)

**Identification Data:**

a. Name ______
b. Relationship with head of family: Self/Wife/son/daughter/any other ________
c. Age ______
d. Religion ______
e. Education ______
f. Occupation ______
g. Monthly income ________
h. Gender: Male/Female ______
i. Marital Status ________
j. Address ______
k. Contact No. ______

**hand washing**

(Attach additional sheets if required)

**Signature of the Academic Counselor/ Supervisor**
Activity 11: Hand Washing Skills

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
c. Age______
d. Religion_______
e. Education ____________
f. Occupation______
g. Monthly income __________
h. Gender: Male/Female __________
i. Marital Status ___________
j. Address__________
k. Contact No._________

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 11: Hand Washing Skills

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
d. Religion_______
e. Education_____________
f. Occupation_______
g. Monthly income__________
h. Gender: Male/Female __________
i. Marital Status _______________
j. Address_____________
k. Contact No._________

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 11: Hand Washing Skills

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age______

d. Religion_____

e. Education____________

f. Occupation_______

g. Monthly income__________

h. Gender :Male/Female__________

i. Marital Status ____________

j. Address__________

k. Contact No.__________

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 11: Hand Washing Skills

Identification Data:

a. Name ______

b. Relationship with head of family: Self/Wife/son/daughter/any other __________

c. Age____

d. Religion____

e. Education __________

f. Occupation____

g. Monthly income __________

h. Gender : Male/Female __________

i. Marital Status __________

j. Address________

k. Contact No._______

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 11: Hand Washing Skills  

**Identification Data:**

a. Name ______

b. Relationship with head of family: Self/Wife/son/daughter/any other ______

c. Age____

e. Education__________

g. Monthly income__________
i. Marital Status __________

(Attach additional sheets if required)

**hand washing**

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 12: Bio-medical Waste Management

- Visit a Ward in a selected health facility wherever applicable
- Observe the bio-medical waste management system followed.
- Fill up the check list given below:
- Write your observation and remarks
- Record the findings as per observation and availability in a particular health facility

**Identification Data:**

a. Name ________
b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
c. Age__________
d. Religion_______
e. Education ____________
f. Occupation________
g. Monthly income ____________
h. Gender : Male/Female ____________
i. Marital Status ____________
j. Address_________
k. Contact No.________

Name of the Health Facility - DH/CHC/PHC/SC/……. Date : __________

**Check List for Bio-medical Waste Management – DH**

<table>
<thead>
<tr>
<th>Health Facility / Ward</th>
<th>Response</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Black bags</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Located at right place</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Placed on stand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contain only non-infected waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it torn?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available sufficiently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collected daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yellow bags</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Located at right place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placed on stand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contain only infected waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it torn /leaking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available sufficiently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collected daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bleaching solution</strong></td>
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</tbody>
</table>

Refer:
BNS: 041
Block :1 Unit : 6
BNSL-043
Block: 2 Unit:1
<table>
<thead>
<tr>
<th>Question</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is it prepared today?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separate bucket for needle/sharps and other Plastic material</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Does the bucket contain mesh?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available in sufficient quantity?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it covered properly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Needle destroyers</strong></td>
<td></td>
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</tr>
<tr>
<td>Present</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location is appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Syringes</strong></td>
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<td></td>
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Comments: ___________________________________________________________________

Signature: _______________

Signature of the Academic Counselor/ Supervisor
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General Comments: _____________________________________________________________

Signature: ________________

**Signature of the Academic Counselor/ Supervisor**
Name of the Health Facility - DH/CHC/PHC/SC/…… Date : ______________

Check List for Bio-medical Waste Management – PHC

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Yellow bags

| Located at right place |          |         |
| Placed on stand        |          |         |
| Contain only infected waste | | |
| Is it torn /leaking?   |          |         |
| Available sufficiently |          |         |
| Collected daily        |          |         |

Bleaching solution

| Is it prepared today? |          |         |
| Separate bucket for needle/sharps and other Plastic material | | |
| Does the bucket contain mesh? | | |
| Available in sufficient quantity? | | |
| Is it covered properly? |          |         |

Needle destroyers

| Present |          |         |
| Working |          |         |
| Location is appropriate |          |         |

Syringes

| All syringes are in bucket for |          |         |
disinfection
Collected daily

**Gloves**
Disposed in bleaching solution
Available in sufficient quantity
Available of appropriate size

**Housekeeping**

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Signature of the Academic Counselor/ Supervisor
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Collected daily

**Gloves**

- Disposed in bleaching solution
- Available in sufficient quantity
- Available of appropriate size

**House keeping**

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General Comments: ___________________________________________________________

Signature: __________________

Signature of the Academic Counselor/ Supervisor
Activity 12: Bio-medical Waste Management

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
c. Age______
d. Religion______
e. Education __________
f. Occupation__________
g. Monthly income__________
h. Gender : Male/Female __________
i. Marital Status ____________
j. Address__________
k. Contact No._______

Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 12: Bio-medical Waste Management  

Identification Data:

a. Name 

b. Relationship with head of family: Self/Wife/son/daughter/any other 

c. Age 

d. Religion 

e. Education 

f. Occupation 

g. Monthly income 

h. Gender: Male/Female 

i. Marital Status 

j. Address 

k. Contact No. 

Check List for Bio-medical Waste Management 

(Attach additional sheets if required) 

Signature of the Academic Counselor/ Supervisor
### Activity 12: Bio-medical Waste Management (CHC-2)

**Identification Data:**
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- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
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- e. Education_____________
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**Check List for Bio-medical Waste Management**

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 12: Bio-medical Waste Management  

Identification Data:

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e. Education _____________

f. Occupation______

g. Monthly income __________

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i. Marital Status __________

j. Address_________

k. Contact No._______

Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 12: Bio-medical Waste Management

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Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 12: Bio-medical Waste Management

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Check List for Bio-medical Waste Management

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Activity 12: Bio-medical Waste Management

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Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 13: Procedures for basic tests (PSC/DH-1)

Urine test for sugar albumin and pregnancy Guidelines

- Select two patients and two pregnant women who requires urine investigation
- Perform following tests:
  - Sugar and Albumin
  - Pregnancy Test
- Record the result in the format provided in the logbook.

Blood Test

- Select two patients and test blood sample for following:
  - Malaria using Rapid Test Kit (Section 3.4, 3.5)
  - Peripheral Smear Preparation
  - Rapid test kit for Typhoid (Section 3.6)
  - Record the result for 5 patients in logbook.

Collection of Stool and sputum sample

- Select two patients each
- Read Section 2.4, 2.5
- Collect blood sample as per procedure given in Section 2.6

Name of the Health Facility as given below ______________________ Date: ______________

Date of Registration: _______ Registration No. _______

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History of present illness _________________________________________

History of past medical illness _______________________________________

Family h/o medical illness __________________________________________

Refer:
Block: 2
Unit: 2/Sec 2.3, 2.4, 2.5, 2.6
Unit: 3
BNSL-043
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Signature of the Academic Counselor/ Supervisor
Activity 13: Procedures for basic tests  

Name of the Health Facility as given below _____________________ Date:______________

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Signature of the Academic Counselor/ Supervisor
Activity 13: Procedures for basic tests

(PSC/DH-2)

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Activity 13: Procedures for basic tests  

Name of the Health Facility as given below _____________________ Date:______________

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Signature of the Academic Counselor/ Supervisor

196
Activity 13: Procedures for basic tests (CHC-2)

Name of the Health Facility as given below ___________________________ Date: ____________

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Activity 13: Procedures for basic tests  (PHC-1)

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Signature of the Academic Counselor/ Supervisor
Activity 13: Procedures for basic tests

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(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 13: Procedures for basic tests

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _____________
  c. Age _______
  d. Religion _______
  e. Education ______________
  f. Occupation _______
  g. Monthly income __________
  h. Gender : Male/Female _______
  i. Marital Status __________
  j. Address __________
  k. Contact No. _______

<table>
<thead>
<tr>
<th>Urine Tests</th>
<th>Reports and results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid
(PSC/DH-1)

Oral Medication
- Select two patients on oral medication, injections/ IV fluids
- Administer medication injection/IV Fluid as prescribed (written order).
- Record the details of patients in logbook as per given format
- Monitor the patient as required

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  c. Age_____          d. Religion______
  e. Education ___________   f. Occupation_____
  g. Monthly income ________  h. Gender: Male/Female __________
  i. Marital Status ___________  j. Address________
  k. Contact No.________

History of present illness _________________________________________

History of past medical illness _________________________________________

Family h/o medical illness _________________________________________

<table>
<thead>
<tr>
<th>S.No</th>
<th>Method</th>
<th>Patient Profile</th>
<th>Drugs dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td></td>
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<tr>
<td>3</td>
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<td>4</td>
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<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Injection</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>---</td>
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<td>---</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>IV Fluids</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid
(PSC/DH-2)

Name of the Health Facility _____________________ Date:_________________

Date of Registration:_______ Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other _________
   c. Age________
   d. Religion_______
   e. Education____________
   f. Occupation_______
   g. Monthly income________ 
   h. Gender:Male/Female _________
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Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid
(CHC-1)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
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Signature of the Academic Counselor /Supervisor
## Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid (CHC-1)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
- d. Religion_______
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- f. Occupation_______
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Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid
(CHC-2)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
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Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid
(PHC-1)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
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  d. Religion_______
  e. Education_____________
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  k. Contact No._______

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Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid (PHC-2)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _________
c. Age_______
d. Religion_______
e. Education __________
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k. Contact No._______

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<th>Drugs dispensed</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid (SC-1)

Name of the Health Facility _____________________ Date: ________________
Date of Registration: ________ Registration No. __________

Identification Data:
   a. Name ______
   b. Relationship with head of family: Self/Wife/son/daughter/any other ______
   c. Age ______
   d. Religion ______
   e. Education ______
   f. Occupation ______
   g. Monthly income ______
   h. Gender: Male/Female ______
   i. Marital Status ______
   j. Address ______
   k. Contact No. ______

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<th>Patient Profile</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor / Supervisor
Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid

Name of the Health Facility _____________________ Date:________________
Date of Registration:_______ Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
   c. Age_______
   d. Religion_______
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   f. Occupation_______
   g. Monthly income __________
   h. Gender :Male/Female _________
   i Marital Status ____________
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   k. Contact No._______

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<tr>
<th>Method</th>
<th>Patient Profile</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor
Activity 15: Examination of Lumps and joint pain  

(PSC/DH-1)

Guidelines:
- Select two patients with Lump and joint pain
- Perform assessment and examination with help of Academic Counselor
- Provide care as planned
- Record the findings

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation_______
- g. Monthly income _______
- h. Gender :Male/Female _______
- i. Marital Status __________
- j. Address_________
- k. Contact No._________

History of present illness _________________________________________

History of past medical illness _________________________________

Family h/o medical illness _______________________________________

Ask the following:

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<thead>
<tr>
<th>S.No.</th>
<th>Question</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When was the lump first noticed? (Duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>What made the patient notice the lump? (First symptom)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>What are the symptoms related to the lump? (Other symptoms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Has the lump changed in size, texture since it was first noticed? (Progression)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Does the lump ever disappear (persistence)? What makes the lump to reappear?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has the patient ever had any other lumps? (Multiplicity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>What does the patient think caused the lump? (Cause)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Is there loss of bodyweight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Is there recurrence after operation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and examination</td>
<td>Findings</td>
<td>Management / Referral</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>1. Look (observation)</strong></td>
<td>Location of lump/position/Contour/ Regular/Irregular/Pulsation: check for Aneurism/High Blood Flow/ Number of lumps/swellings /Shape: Spherical/ Hemispheric/Pear or Kidney shape/ Size of lump / Color and texture of overlying skin: Check for smoother and shiny or thick and rough skin, scars, ulcers, discharging sinuses, peaud’orange) / Check for Abnormal vessels / Impulse on cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Feel the lump/swelling (palpation)</strong></td>
<td>Check temperature by touching and compare it with nearby / adjacent normal skin other than the lump swelling/ Tenderness: Feeling pain on touch / Surface: Check for smoothness/regularity/nodularity /Edge: Check for well defined or indistinct edges / Consistency: Check for stony hard/ firm/ rubbery/spongy/soft consistency / Cough impulse: Reducible (Ask the patient to cough and see if the lump increase in size or not. If size increases by to reduce it by spreading the lump to see whether such as a bony</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
prominence, joint etc.). It is reducable or not eg. hernias - don't forget cough impulse/

**Position**: Measured from a landmark/

**Size**: Measure with a measuring tape /Thrill or pulsation /

3. Press:

**Pulsatility**: Check whether the lump is pulsatile or not. It should be expansile pulsation or transmitted pulsation) /

**Compressibility**: Disappear on pressure and reappear on release Emptying /

**Reducibility**: Reappear only on application of another force e.g. cough /

**Fluctuation**: It is checked by 2 fingers moved apart when middle area pressed.

4. Percussion:

Put three fingers (index, middle and ring) of left hand over the lump or swelling. Using middle finger of right hand tap gently over the middle finger of left hand over the lump and listen to the sound. It can be dull or resonant. Dull indicates solid nature. Resonance indicates presence of gas.

5. Move (This is to check plane of attachment)

Skin tethering (To see skin fixed with tissues lying beneath. Attempt to pick up a fold of skin over the swelling and compare with other side).
Deeper structures (attempt to move the swelling in different planes relative to surrounding tissues).

Muscles and tendons (palpate the swelling whilst asking the patient to use the relevant muscle).

**Assessment of joint pain**
- Select two patients with Joint pain
- Perform examination and record the findings.
- Make appropriate referral if required
- Plan care and take action
- Record the findings

**Name of the Health Facility** __________________________ Date: ______________

Date of Registration: ______ Registration No. ______

**Identification Data:**
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation ______
- g. Monthly income _________
- h. Gender :Male/Female ______
- i. Marital Status ____________
- j. Address_________
- k. Contact No._______

History of present illness _______________________________________

History of past medical illness _____________________________________

Family h/o medical illness _________________________________________

<table>
<thead>
<tr>
<th>History</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Medical Disease related to Heart, Lungs, Abdomen, Diabetes or Chronic disease</td>
<td></td>
</tr>
<tr>
<td>b) Surgical Disease or Trauma or Any surgery</td>
<td></td>
</tr>
<tr>
<td>c) Dietary History</td>
<td></td>
</tr>
<tr>
<td>d) History of Job /Sports</td>
<td></td>
</tr>
</tbody>
</table>
### Physical Assessment

**General examination**
- Pulse
- BP
- Respiration
- Temperature
- Level of Consciousness

### Site of Pain

**Onset of pain (Severe, Sudden, Slow, Steady)**

**Provoking factors (exertion, position, sports, work activities, cold weather, morning and evening time)**

### Character of pain

### Associated Symptoms (Low range of motion, inability to do daily work)

### Time Course of pain (Intermittent, Continuous)

### Exacerbating/Relieving Symptoms

### Severity

Rate the pain from 1-10 for 1 being the slight pain and 10 being the worst pain

### Possible diagnosis:

### Advices and Referral details:

(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
### Activity 15: Examination of Lumps and joint pain

Name of the Health Facility ____________________ Date: ____________

Date of Registration: ________  Registration No. ________

**Identification Data:**

a. Name ________

b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age ________  

d. Religion ________

e. Education ________________  

f. Occupation ________

g. Monthly income ____________  

h. Gender: Male/Female ________

i. Marital Status ________________  

j. Address ________________  

k. Contact No. __________

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<th>Question</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Assessment of lumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of joint pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems (PSC/DH-1)

- Select two patients having eye problems
- Take history and make assessment.
- Plan action to be taken and care as per need
- Record the findings.

**Name of the Health Facility as given below _____________________ Date:______________**

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_____ d. Religion______

e. Education ___________ f. Occupation_____

g. Monthly income ___________ h. Gender :Male/Female __________

i. Marital Status ___________ j. Address_________

k. Contact No._______

History of present illness _______________________________________

History of past medical illness ____________________________________

Family h/o medical illness _________________________________________

Assess the patient for the following parameters, identify problem and take need based action

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pain, itching, or sensation of a foreign body in the eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Photosensitivity (aversion to bright light)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Redness or small red lines in the white of the eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discharge of yellow pus that may be crusty on waking up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Watering of eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Whitening of black of eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Swollen eyelids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Constant involuntary blinking (blepharospasm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Crusting over of the eyelid</td>
<td></td>
<td></td>
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</tbody>
</table>

Refer:
Block: 2
Unit: 5
BNSL-043
Referral and follow up (if required)

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems

Name of the Health Facility as given below __________________ Date:______________
Date of Registration: ________ Registration No. ________

Identification Data:
a. Name ________
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age________
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g. Monthly income ________
h. Gender : Male/Female ___________
i. Marital Status __________
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Assess the patient for the following parameters, identify problem and take need based action

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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems  (CHC-1)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems (CHC-2)

Name of the Health Facility as given below ____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems (PHC-1)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
- a. Name _______
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- h. Gender :Male/Female __________
- i. Marital Status ___________
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- k. Contact No._______

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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems (PHC-2)

Name of the Health Facility as given below ___________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age______
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  e. Education __________
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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
- d. Religion_______
- e. Education _____________
- f. Occupation_______
- g. Monthly income __________
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Signature of the Academic Counselor/Supervisor
Activity 16: Assessment of the patient with eye problems (SC-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
  c. Age_______
  d. Religion_______
  e. Education _____________
  f. Occupation_______
  g. Monthly income _________
  h. Gender: Male/Female _________
  i. Marital Status ___________
  j. Address__________
  k. Contact No._______

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<th>Management / Referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems

- Select patient each with problems of ear, nose & throat.
- Plan care and take action
- Record the findings
- Make appropriate referral if required

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age______
  d. Religion_______
  e. Education ___________
  f. Occupation_____
  g. Monthly income ________
  h. Gender :Male/Female __________
  i. Marital Status __________
  j. Address_________
  k. Contact No._______

History of present illness _________________________________________
History of past medical illness _______________________________________
Family h/o medical illness __________________________________________

Problem of Ear

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
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<tbody>
<tr>
<td>History : H/o earache occurring within 3 to 5 days after an attack of common cold/ Fever/ Decreased hearing/ Pus discharge from ear/ Child is irritable</td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems

(PSC/DH-2)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: ________ Registration No. ________

**Identification Data:**

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<tr>
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<td>f.</td>
<td>Occupation__________</td>
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<td>g.</td>
<td>Monthly income_________</td>
<td>h.</td>
<td>Gender :Male/Female ____________</td>
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<tr>
<td>i.</td>
<td>Marital Status__________</td>
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<td>Address__________</td>
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<td>k.</td>
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Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (CHC-1)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. ______

Identification Data:
  a. Name ________
  b. Relationship with head of family: Self/Wife/son/daughter/any other ________
  c. Age ________
  d. Religion ________
  e. Education ____________
  f. Occupation ________
  g. Monthly income ________
  h. Gender : Male/Female ________
  i. Marital Status ________
  j. Address ________
  k. Contact No. ________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (CHC-2)

Name of the Health Facility _____________________ Date: ________________
Date of Registration: _______ Registration No. ________

Identification Data:

a. Name __________
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age ________
d. Religion ________
e. Education ____________
f. Occupation ________
g. Monthly income ___________
h. Gender: Male/Female ____________
i. Marital Status ____________
j. Address ____________
k. Contact No. ________

Problem of Ear

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Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_________ d. Religion_______
e. Education _________________ f. Occupation_______
g. Monthly income ___________ h. Gender :Male/Female _________
i. Marital Status ______________ j. Address__________
k. Contact No.________

**Problem of Ear**

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Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems

(ATTACH ADDITIONAL SHEETS IF REQUIRED)

Name of the Health Facility _____________________ Date: _____________
Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age______

d. Religion_______

e. Education _____________

f. Occupation_____

g. Monthly income _______

h. Gender :Male/Female _________

i. Marital Status ___________

j. Address_________

k. Contact No._______

Problem of Ear

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Signature of the Academic Counselor/Supervisor

(ATTACH ADDITIONAL SHEETS IF REQUIRED)
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (SC-1)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name ________
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age ________
  d. Religion ________
  e. Education __________
  f. Occupation ________
  g. Monthly income __________
  h. Gender :Male/Female ________
  i. Marital Status __________
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Problem of Ear

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems

Name of the Health Facility _____________________ Date: ______________
Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name_____
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_____
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f. Occupation_____
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**Problem of Ear**

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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems (PSC/DH-1)

- Select 2 persons (of any age groups) having dental problems.
- Assess the problem
- Assess severity of dental problem
- Take appropriate action.
- Record the findings

Name of the Health Centre ________________________   Date:  ________________

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______   Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other _________
   c. Age_______
   d. Religion_______
   e. Education _____________
   f. Occupation_______
   g. Monthly income__________
   h. Gender :Male/Female _________
   i. Marital Status ____________
   j. Address__________
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Assessment and Management

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<td>History of present illness</td>
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<td>History of past medical illness</td>
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<tr>
<td>Family h/o medical illness</td>
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<tr>
<td>Assess Problems</td>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems (PSC/DH-2)

Name of the Health Centre ________________________   Date:  ________________

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age______

d. Religion______

e. Education _____________

f. Occupation______

g. Monthly income __________

h. Gender :Male/Female _______

i. Marital Status __________

j. Address_________

k. Contact No._______

**Assessment and Management**

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**Signature of the Academic Counselor/Supervisor**
Activity 18: Identification and Management of Dental problems  (CHC-1)

Name of the Health Centre __________________________  Date:  ______________

Name of the Health Facility as given below ______________________ Date:____________

Date of Registration:_______  Registration No._______

Identification Data:
\[ a. \text{Name } \]
\[ b. \text{Relationship with head of family: Self/Wife/son/daughter/any other } \]
\[ c. \text{Age} \]
\[ d. \text{Religion} \]
\[ e. \text{Education} \]
\[ f. \text{Occupation} \]
\[ g. \text{Monthly income} \]
\[ h. \text{Gender :Male/Female} \]
\[ i. \text{Marital Status} \]
\[ j. \text{Address} \]
\[ k. \text{Contact No.} \]

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Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems  (CHC-2)

Name of the Health Centre ________________________   Date:  ________________

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______              Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age________

d. Religion_______

e. Education ___________

f. Occupation_____

g. Monthly income __________

h. Gender :Male/Female __________

i. Marital Status __________

j. Address_________

k. Contact No._______

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Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems  (PHC-1)

Name of the Health Centre __________________________  Date: ________________

Name of the Health Facility as given below __________________________ Date: ________________

Date of Registration: ______  Registration No. ______

**Identification Data:**
- a. Name ________
- b. Relationship with head of family: Self/Wife/son/daughter/any other ________
- c. Age______
- d. Religion______
- e. Education __________
- f. Occupation________
- g. Monthly income________
- h. Gender :Male/Female ________
- i. Marital Status __________
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Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems  (PHC-2)

Name of the Health Centre ________________________   Date:  ________________

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______   Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age______  
  d. Religion______
  e. Education ____________
  f. Occupation_____
  g. Monthly income __________   
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  i. Marital Status ____________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems

(Sc-1)

Name of the Health Centre __________________________ Date: ______________

Name of the Health Facility as given below __________________________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:
   a. Name _______ 
   b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
   c. Age_________ 
   d. Religion_______
   e. Education ____________ 
   f. Occupation__________
   g. Monthly income __________ 
   h. Gender : Male/Female ____________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 18: Identification and Management of Dental problems (SC-2)

Name of the Health Centre ________________________   Date:  ________________

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:________   Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age______
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds (PSC/DH-1)

- Select 2 persons (of any age groups) having wound.
- Assess the problem
- Take appropriate action.
- Record the findings

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
  c. Age_______
  d. Religion_______
  e. Education_____________
  f. Occupation_______
  g. Monthly income_________
  h. Gender :Male/Female _________
  i. Marital Status __________
  j. Address_________
  k. Contact No._______

History of present illness ________________________________________________________

History of past medical illness ____________________________________________________

Family h/o medical illness _________________________________________________________

Assessment and Management

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds  
(PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age_______ d. Religion_________
  e. Education ____________
  f. Occupation_____
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Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds  (CHC-1)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _______
  c. Age________
  d. Religion_______
  e. Education ____________
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Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds  

Name of the Health Facility as given below _____________________ Date:__________

Date of Registration:______ Registration No.______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age________

d. Religion_______

e. Education __________

f. Occupation_____

g. Monthly income________

h. Gender :Male/Female________

i. Marital Status __________

j. Address________

k. Contact No._______

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Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds (PHC-1)

Name of the Health Facility as given below _____________________ Date: ________________
Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_________
- d. Religion_________
- e. Education_________
- f. Occupation_________
- g. Monthly income_________
- h. Gender: Male/Female __________
- i. Marital Status_________
- j. Address_________
- k. Contact No._________

**Assessment and Management**

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Signature of the Academic Counselor/Supervisor
Activity 19: Suturing of superficial Wounds  (PHC-2)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______    Registration No._______

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other _________
   c. Age__________    d. Religion_______
   e. Education ____________    f. Occupation______
   g. Monthly income ________    h. Gender :Male/Female __________
   i. Marital Status ____________    j. Address__________
   k. Contact No._______

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Signature of the Academic  Counselor/Supervisor
Activity 19: Suturing of superficial Wounds  

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other _________
   c. Age_________ d. Religion_______
   e. Education ____________
   f. Occupation_______
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   i. Marital Status __________
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Signature of the Academic  Counselor/Supervisor
Activity 19: Suturing of superficial Wounds

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age_________ d. Religion_______
  e. Education ______________ e. Occupation______
  g. Monthly income ___________ h. Gender :Male/Female ___________
  i. Marital Status ____________ j. Address_________
  k. Contact No.________

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Signature of the Academic  Counselor/Supervisor
Activity 20: Basic Life Support

- Practice the procedure of Basic Life Support in manikin
- Record the steps of procedure

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age______
  d. Religion______
  e. Education ______________
  f. Occupation_______
  g. Monthly income _________
  h. Gender :Male/Female _________
  i. Marital Status ____________
  j. Address_________
  k. Contact No._________

History of present illness _________________________________________________________

History of past medical illness ___________________________________________________

Family h/o medical illness________________________________________________________

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<tr>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 20: Basic Life Support (PSC/DH-2)

- Practice the procedure of Basic Life Support in manikin
- Record the steps of procedure

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age______
  d. Religion_______
  e. Education ____________
  f. Occupation______
  g. Monthly income ________
  h. Gender :Male/Female ____________
  i. Marital Status __________
  j. Address_________
  k. Contact No._______

History of present illness _________________________________________________________

History of past medical illness ____________________________________________________

Family h/o medical illness________________________________________________________

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<tr>
<td>Steps:</td>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Refer:
Block: 3
Unit:1
BNSL-043
Activity 20: Basic Life Support (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age______

d. Religion_______

e. Education ______________

f. Occupation______

g. Monthly income __________

h. Gender :Male/Female __________

i. Marital Status ____________

j. Address_________

k. Contact No._______

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Signature of the Academic Counselor/Supervisor
Activity 20: Basic Life Support (CHC-1)

Name of the Health Facility as given below _____________________ Date: ___________

Date of Registration: _______ Registration No. _______

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age _______
- d. Religion _______
- e. Education ___________
- f. Occupation _______
- g. Monthly income ___________
- h. Gender: Male/Female _______
- i. Marital Status ___________
- j. Address ___________
- k. Contact No. _______

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 20: Basic Life Support (PHC-1)

Name of the Health Facility as given below _____________________ Date: ____________

Date of Registration: _______    Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _______
c. Age_______    d. Religion_______
e. Education ____________
f. Occupation_______
g. Monthly income _________
h. Gender :Male/Female __________
i. Marital Status __________
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k. Contact No.________

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<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 20: Basic Life Support (PHC-2)

Name of the Health Facility as given below _____________________ Date: ______________
Date of Registration: _______ Registration No. ________

**Identification Data:**

a. Name ________
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age ________
d. Religion ________
e. Education ______________
f. Occupation ________
g. Monthly income __________
h. Gender: Male/Female __________
i. Marital Status ____________
j. Address _______________
k. Contact No. ________

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<tr>
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<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
# Activity 20: Basic Life Support

**Identification Data:**
- Name _______
- Relationship with head of family: Self/Wife/son/daughter/any other ___________
- Age______
- Religion______
- Education ______________
- Occupation______
- Monthly income ______________
- Marital Status ______________
- Address_________
- Contact No._______

<table>
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<tr>
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<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
Activity 20: Basic Life Support

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: ______  Registration No. _______

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _______
c. Age _______
d. Religion _______
e. Education _______
f. Occupation _______
g. Monthly income _______
h. Gender: Male/Female _______
i. Marital Status _______
j. Address _______
k. Contact No. _______

Assessment | Findings | Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies (PSC/DH-1)

Guidelines:
- Select two patients in a District Hospital
- Perform health assessment and observation in in-patient and Out-patient Departments
- Provide care as per need
- Identify the type of illness
- Record the action taken
- Make appropriate referral if required
- Write a brief report

Name of the Health Facility _____________________ Date: ________________
Date of Registration: _______ Registration No. _______

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age______
- d. Religion______
- e. Education __________
- f. Occupation______
- g. Monthly income ______
- h. Gender : Male/Female __________
- i. Marital Status _______
- j. Address_________
- k. Contact No._______

History of present illness _____________________________________________

History of past medical illness _________________________________________

Family h/o medical illness _____________________________________________

Poisoning

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Poisoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acid Poisoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alkali Poisoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------</td>
<td></td>
</tr>
<tr>
<td>Dog Bite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snake Bite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect bites and stings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burns and scalds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma (RTA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drowning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)
Activity 21: Identification and care of patients with common conditions and emergencies  
(PSC/DH-2)

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
- c. Age_______
- d. Religion_______
- e. Education ____________
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Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies  

Name of the Health Facility _____________________ Date: ________________

Date of Registration: _______   Registration No. ________

**Identification Data:**

a. Name ________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies (CHC-2)

Name of the Health Facility _____________________ Date: ______________ 
Date of Registration: ____ Registration No. ________

Identification Data:
  a. Name ______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
  c. Age______
  d. Religion_______
  e. Education _____________
  f. Occupation____
  g. Monthly income _________
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  k. Contact No._______

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<tr>
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<th>Action Taken</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies (PHC-1)

Name of the Health Facility _____________________ Date: ________________

Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age__________
- d. Religion________
- e. Education __________
- f. Occupation _______
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies (PHC-2)

Name of the Health Facility ______________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age______
- d. Religion_______
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Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies  (SC-1)

Name of the Health Facility _____________________ Date: ________________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name ________
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age________
  d. Religion_______
  e. Education____________
  f. Occupation_______
  g. Monthly income __________
  h. Gender: Male/Female _________
  i. Marital Status ____________
  j. Address________
  k. Contact No.___________

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<th>Assessment</th>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 21: Identification and care of patients with common conditions and emergencies  
(SC-2)

<table>
<thead>
<tr>
<th>Name of the Health Facility</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Registration:</td>
<td>Registration No.</td>
</tr>
</tbody>
</table>

**Identification Data:**

- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
- c. Age______
- d. Religion______
- e. Education __________
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- g. Monthly income __________
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- k. Contact No.________

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<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 22: Aches and Pain

Guidelines:
Select 2 patients with aches and pains assess & identify problem.
- Make assessment and observation in inpatient and Out Patient Departments
- Identify problem if any
- Provide care as per need
- Make appropriate referral if required
- Record the action taken
- Write a brief report

Name of the Health Facility _____________________ Date: ______________
Date of Registration:________ Registration No.________

Identification Data:
a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other __________
c. Age______ d. Religion______
e. Education__________ f. Occupation______
g. Monthly income__________ h. Gender: Male/Female ___________
i. Marital Status__________ j. Address__________
k. Contact No.__________

History of present illness _________________________________________
History of past medical illness _____________________________________
Family h/o medical illness _________________________________________

Assessment of Abdominal Pain

<table>
<thead>
<tr>
<th>History</th>
<th>Findings</th>
<th>Management/Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Medical Disease related to Heart, Lungs, Abdomen, Diabetes or Chronic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Surgical Disease or Trauma or Any surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Menstrual History (for Women)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Obstetrical History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Dietary History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) History of Substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Food allergies (if any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Medication history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respiration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Temperature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Levels of Consciousness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site of Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Upper/Lower, Quadrant affected, Possible organ affected, Centrally Located)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Onset of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Before taking food, After taking food, Sudden, Slow, Steady)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Character of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Stabbing, Cramping, Burning, Dull, Acute, Chronic, Colicky)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Back, Chest, Over the abdomen, Localized)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Nausea/Vomiting, Bleeding, Bleeding per vagina/Hematemesis, Diarrhea, Heartburn, Burping, Jaundice, Fever, Utricaria, Vaginal Discharge, Anorexia, Constipation, Dysuria, Hematuria, Urine Urgency, Cloudy Urine, Pallor, Hard or Rigid abdomen, Cullens Sign/Grey Turners Sign, Lethargy, Guarding, Weight loss, Bloating, Change in Bowel Habits, Dehydration, Tenderness, lumps)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time Course of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Has become worse over the time, Has become better over the time, No change)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exacerbating/Relieving Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Position, Diarrhea/Passage of Stool/Urine, Coughing, Food, Medicines)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate the pain from 1-10 for 1 being the slight pain and 10 being the worst pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possible organ affected</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Findings on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inspection</td>
</tr>
<tr>
<td>• Auscultation</td>
</tr>
<tr>
<td>• Percussion</td>
</tr>
<tr>
<td>• Palpation</td>
</tr>
</tbody>
</table>

| Possible problem of the patient: |

| Advices and Referral details: |
## Assessment of Chest Pain

<table>
<thead>
<tr>
<th>Take History</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Medical Disease related to Heart, Lungs, Abdomen, Diabetes or Chronic disease</td>
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<td></td>
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<tr>
<td>b) Surgical Disease or Trauma or Any surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Dietary History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) History of Substance abuse/Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Food allergies (if any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Medication history</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physical Assessment

**General examination**
- Pulse
- BP
- Respiration
- Temperature
- Levels of Consciousness

### Site of Pain

**Onset of pain** (Severe, Sudden, Slow, Steady)

**Provoking factors** (exertion, stress, position, change with repositioning)

**Character of pain** (Stabbing, Cramping, Burning, Aching, Sharp, Continuous, Tearing, Dull, Acute, Chronic)

**Radiation of pain** (Jaw, Arms, Neck, Back, Chest, Arm, Abdomen, Localized)

**Associated Symptoms** (Nausea/Vomiting, Dysnea, Diaphoresis, Weakness, Cough, Joint Pain, Cyanosis, Hemoptysis).

**Time Course of pain** (Intermittent, Continuous)

**Exacerbating/Relieving Symptoms** (Position, Rest, Medication)

**Severity**
Rate the pain from 1-10 for 1 being the slight pain and 10 being the worst pain

**Possible diagnosis of the problem:**

---

*Assessment of Chest Pain is a comprehensive process that involves gathering a detailed history and conducting physical assessments to identify the cause of chest pain.*
Assessment of Back Pain

<table>
<thead>
<tr>
<th>History</th>
<th>Findings</th>
<th>Management / Referral</th>
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<td></td>
</tr>
<tr>
<td>c) Dietary History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) History of Job /Sports</td>
<td></td>
<td></td>
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</tbody>
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Physical Examination
General examination
- Pulse
- BP
- Respiration
- Temperature
- Levels of Consciousness

Site of Pain

Onset of pain (Severe, Sudden, Slow, Steady)

Provoking factors (exertion, position, sports, work activities, cold weather, morning and evening time)

Character of pain

Associated Symptoms

Exacerbating /Relieving Symptoms

Severity
Rate the pain from 1-10 for 1 being the slight pain and 10 being the worst pain

Possible nursing diagnosis:

Advices and Referral details:

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 22: Aches and Pain  

Name of the Health Facility _____________________ Date: ____________

Date of Registration: ______ Registration No. ______

**Identification Data:**
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ________
- c. Age________
- d. Religion________
- e. Education ____________
- f. Occupation________
- g. Monthly income ____________
- h. Gender: Male/Female __________
- i. Marital Status ____________
- j. Address________
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**Assessment of Abdominal Pain**

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Signature of the Academic Counselor/Supervisor
Activity 22: Aches and Pain  

Name of the Health Facility _____________________ Date: ____________

Date of Registration: ________  Registration No. ________

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Signature of the Academic Counselor/Supervisor
Activity 22: Aches and Pain  

Name of the Health Facility _____________________ Date: ____________

Date of Registration: _______  Registration No. _______

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Signature of the Academic Counselor/Supervisor
Activity 22: Aches and Pain

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
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   b. Relationship with head of family: Self/Wife/son/daughter/any other __________
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Assessment of Abdominal Pain

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Signature of the Academic Counselor/Supervisor
### Activity 22: Aches and Pain

**Name of the Health Facility** _____________________  **Date:** ___________

**Date of Registration:** ______  **Registration No.:** ________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ________
- c. Age________
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### Assessment of Abdominal Pain

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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
**Activity 22: Aches and Pain**  
(SCR-1)

Name of the Health Facility _____________________ Date: ________________

Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
- c. Age_________
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**Assessment of Abdominal Pain**

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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 22: Aches and Pain**

Name of the Health Facility _____________________ Date: ____________

Date of Registration:______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age________
- d. Religion_______
- e. Education ____________
- f. Occupation________
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address________
- k. Contact No._______

**Assessment of Abdominal Pain**

<table>
<thead>
<tr>
<th>History</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers

(PSC/DH-1)

Guidelines:

Select 2 patients with fever & identify problem.

- Make assessment and observation in in-patient and Out Patient Departments
- Take measures to provide need based health assessment
- Provide care as per need
- Identify for appropriate referral if situation is not being able to manage by you.
- Record the action taken
- Write a brief report

Name of the Health Facility as given below ___________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age______
d. Religion_______
e. Education _____________
f. Occupation__________
g. Monthly income___________
h. Gender :Male/Female ___________
i. Marital Status ____________
j. Address_________
k. Contact No._______

History of present illness _________________________________________

History of past medical illness _______________________________________

Family h/o medical illness _________________________________________

Assessment for Common Fevers

<table>
<thead>
<tr>
<th>S.No</th>
<th>Signs and Symptoms</th>
<th>Yes</th>
<th>No</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Cardinal Signs and Symptoms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High temperature - above 37°C (98.6°F)</td>
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<tr>
<td></td>
<td>Pallor of skin</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Feeling cold with shivering and chattering teeth</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Hot, flushed skin, body rash and sweating</td>
<td></td>
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<tr>
<td></td>
<td>Headache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>General body aches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Accompanying signs and symptoms</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Nausea, vomiting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Cough</td>
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<td></td>
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</tr>
</tbody>
</table>
Fast breathing
Increased pulse rate
Running nose
Neck stiffness
Difficulty, urgency and burning in urination,
Weight loss
Jaundice
Drowsiness

3 Other signs and symptoms accompanying fever include
Lethargy
Depression
Anorexia (low appetite)
Sleepiness
Myalgia (muscular pain)
Hyperalgesia (increased pain sensitivity)
Decreased ability to concentrate

Additional Assessment
Ask H/o pain in any specific part of the body/taking medication/travelling to areas with endemic infection
Perform thorough physical examination
Any abnormal fluid collection
Investigation
Blood – complete haemogram with ESR, smear for malarial parasite, blood culture, widal test
Urine analysis including culture
X-Ray chest (h/o fever beyond 2 weeks)
USG to rule out amoebic liver abscess
(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers  

Name of the Health Facility as given below _____________________ Date: __________

Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
- c. Age_________
- d. Religion_________
- e. Education ___________
- f. Occupation_______
- g. Monthly income __________
- h. Gender: Male/Female __________
- i. Marital Status ___________
- j. Address_________
- k. Contact No._________

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers  

Name of the Health Facility as given below ________________ Date: ________________

Date of Registration: ______ Registration No. ______

**Identification Data:**

a. Name ______

b. Relationship with head of family: Self/Wife/son/daughter/any other ______

c. Age______

d. Religion______

e. Education ____________

f. Occupation______

g. Monthly income ______

h. Gender :Male/Female ______

i. Marital Status ____________

j. Address ____________

k. Contact No. ______

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers

Name of the Health Facility as given below __________________ Date: ___________

Date of Registration: ______ Registration No. ______

Identification Data:
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age________
- d. Religion_______
- e. Education __________
- f. Occupation_____
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers (PHC-1)

Name of the Health Facility as given below ___________________ Date: ____________

Date of Registration: _______ Registration No. _______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
  c. Age _______ d. Religion _______
  e. Education _____________ f. Occupation ______
  g. Monthly income ___________ h. Gender : Male/Female _________
  i. Marital Status ___________ j. Address ___________
  k. Contact No. _______

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers

Name of the Health Facility as given below _____________________ Date: ____________
Date of Registration: _______ Registration No. ________

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other __________

c. Age_________

d. Religion_______

e. Education ____________
f. Occupation_______

g. Monthly income ____________
h. Gender : Male/Female __________

i. Marital Status ____________
j. Address_________
k. Contact No._________

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers

Name of the Health Facility as given below _____________________ Date: ____________

Date of Registration: _______ Registration No. _______ 

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_______

d. Religion_______

e. Education _____________

f. Occupation________

g. Monthly income __________

h. Gender :Male/Female ________

i. Marital Status ____________

j. Address_________

k. Contact No._________

<table>
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<tr>
<th>Signs and Symptoms</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 23: Common Fevers

Name of the Health Facility as given below _____________________ Date: __________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _______
c. Age______
d. Religion_______
e. Education ________________
f. Occupation_______
g. Monthly income __________
h. Gender : Male/Female _______
i. Marital Status ____________
j. Address_________
k. Contact No. _______

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<th>Signs and Symptoms</th>
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<tbody>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 24: Assessment and care of health problems among elderly

(PSC/DH-1)

- Select 2 elderly patients
- Make assessment
- Provide effective care and assistance.
- Referral and follow up care as per need
- Record action taken

Name of the Health Facility as given below _____________________ Date: ____________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age _______
  d. Religion________
  e. Education_____________
  f. Occupation
  g. Monthly income_________
  h. Gender :Male/Female __________
  i. Marital Status __________
  j. Address_________
  k. Contact No.________

History of present illness _________________________________________

History of past medical illness ____________________________________

Family h/o medical illness _________________________________________

Assessment check list to identify physical problems of elderly

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract /Glaucoma / Retinopathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve deafness / Conductive hearing loss</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fibrositis /Osteoarthritis/ Rheumatoid arthritis / Myositis /Neuritis/ Gout / Spondilitis of spine</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Condition</td>
<td></td>
<td></td>
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<tr>
<td>-------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Dementia / Parkinson’s disease / Alzheimer’s disease</td>
<td></td>
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<tr>
<td>Atherosclerosis/ Thrombus formation/ Myocardial Infarction, Hypertension</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chronic bronchitis / Asthma / Emphysema</td>
<td></td>
<td></td>
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<tr>
<td>Senile wrinkles / Scaly lesions / Scaly dermatosis / Blistering diseases / Neoplastic disorders</td>
<td></td>
<td></td>
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<tr>
<td>Peptic ulcer / Constipation / Ulcerative colitis / Carcinoma of GIT</td>
<td></td>
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</tr>
<tr>
<td>Frequency and urgency of micturation / Nocturia / Dysuria / Enlargement of prostate</td>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 24: Assessment and care of health problems among elderly

Name of the Health Facility as given below _______________________ Date: ______________

Date of Registration: ________ Registration No. ________

Identification Data:
- Name ________
- Relationship with head of family: Self/Wife/son/daughter/any other ________
- Age ________
- Education ________
- Occupation ________
- Monthly income ________
- Marital Status ________
- Address ________
- Contact No. ________

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

290
Activity 24: Assessment and care of health problems among elderly (CHC-1)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age________
- d. Religion_______
- e. Education_________
- f. Occupation_______
- g. Monthly income________
- h. Gender :Male/Female _________
- i. Marital Status ____________
- j. Address_________
- k. Contact No._________

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 24: Assessment and care of health problems among elderly (CHC-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _________
  c. Age________
  d. Religion______
  e. Education ______________
  f. Occupation_______
  g. Monthly income _________
  h. Gender :Male/Female _________
  i. Marital Status ____________
  j. Address________
  k. Contact No._______

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
</tr>
</thead>
<tbody>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 24: Assessment and care of health problems among elderly (PHC-1)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age______

d. Religion______

e. Education ________________

f. Occupation______

g. Monthly income ____________

h. Gender :Male/Female __________

i. Marital Status _______________

j. Address_________

k. Contact No._______

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 24: Assessment and care of health problems among elderly (PHC-2)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
- c. Age________
- d. Religion_______
- e. Education ______________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
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<tbody>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

294
Activity 24: Assessment and care of health problems among elderly (SC-1)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age______
- d. Religion_______
- e. Education ____________
- f. Occupation______
- g. Monthly income _________
- h. Gender : Male/Female _________
- i. Marital Status ____________
- j. Address_________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Assessment of Physical Problems</th>
<th>Findings</th>
<th>Action Taken</th>
<th>Appropriate referral</th>
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</thead>
<tbody>
<tr>
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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
## Activity 24: Assessment and care of health problems among elderly (SC-2)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:________ Registration No.________

### Identification Data:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Name _______</td>
</tr>
<tr>
<td>b.</td>
<td>Relationship with head of family: Self/Wife/son/daughter/any other ____________</td>
</tr>
<tr>
<td>c.</td>
<td>Age________</td>
</tr>
<tr>
<td>d.</td>
<td>Religion______</td>
</tr>
<tr>
<td>e.</td>
<td>Education________</td>
</tr>
<tr>
<td>f.</td>
<td>Occupation______</td>
</tr>
<tr>
<td>g.</td>
<td>Monthly income________</td>
</tr>
<tr>
<td>h.</td>
<td>Gender :Male/Female ____________</td>
</tr>
<tr>
<td>i.</td>
<td>Marital Status ____________</td>
</tr>
<tr>
<td>j.</td>
<td>Address________</td>
</tr>
<tr>
<td>k.</td>
<td>Contact No.________</td>
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</tbody>
</table>

### Assessment of Physical Problems

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<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Physical Problems</td>
<td>Findings</td>
<td>Action Taken</td>
<td>Appropriate referral</td>
</tr>
<tr>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 25: Health Assessment of Women (15 to 45 years of age) (PSC/DH-1)

Guidelines:
- Select any two cases for Health Assessment of Women (15 to 45 years of age)
- Record the findings in the format.
- Identify any problem if any

Name of the Health Centre ________________________ Date : __________________

Date of Registration: ________ Registration No.________

Identification Data:

<table>
<thead>
<tr>
<th>Name of the woman</th>
<th>Name of the Husband (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age________</td>
<td>Age________</td>
</tr>
<tr>
<td>Religion________</td>
<td>Education____</td>
</tr>
<tr>
<td>Education____</td>
<td>Occupation____</td>
</tr>
<tr>
<td>Occupation____</td>
<td>Contact No.____</td>
</tr>
<tr>
<td>Marital Status________</td>
<td></td>
</tr>
<tr>
<td>Address________________</td>
<td></td>
</tr>
<tr>
<td>Contact No.____</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management / Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habits: Smoking/ alcohol Drug/ Tobacco/ Excessive tea or coffee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet: Vegetarian/ Non vegetarian/ egg vegetarian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life style: Sedentary/ exercise/ relaxation/ Yoga/ meditation/ any other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hobbies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene: Good/ Fair/ poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest and sleep (No. of hours at night _____ and day_____.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elimination habits: Bowel: Good/ Fair/ Poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder: Good/ fair/ Poor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Personal Medical History

| Childhood disease |     |                       |
| Immunization status |     |                       |
| Hospitalization (reasons and duration) |     |                       |
| Drug sensitivity (specify) |     |                       |
| Allergies (specify) |     |                       |
| History of any of the following diseases:- Diabetes Mellitus/Hypertension/Heart disease/Tuberculosis/ Rheumatic fever/Asthma /Anaemia/Cancer/Thyroid disorder/ Sexually |     |                       |
transmitted disease/ H/o any operations / H/o blood transfusion

<table>
<thead>
<tr>
<th>Menstrual History</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age at menarche</td>
</tr>
<tr>
<td>• H/o menstrual cycle</td>
</tr>
<tr>
<td>• duration/Date of last menstrual period (LMP)/</td>
</tr>
<tr>
<td>• Amount of blood flow</td>
</tr>
<tr>
<td>• Any complaints like dysmenorrhoea</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital and Sexual History</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age at marriage</td>
</tr>
<tr>
<td>• Duration of marriage</td>
</tr>
<tr>
<td>• Duration of co-habilitation</td>
</tr>
<tr>
<td>• Relationship with spouse</td>
</tr>
<tr>
<td>• Sexually active/ inactive/ Contraceptive history and practice</td>
</tr>
<tr>
<td>• History of presence of sexually transmitted disease (if any)/Type/Treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obstetrical History</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gravida/ Para/ Number of living children/</td>
</tr>
<tr>
<td>• H/o abortion/still birth /infant death/</td>
</tr>
<tr>
<td>• H/o previous pregnancies/deliveries/</td>
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<tr>
<td>• H/o any caesarean section/Any signs of present pregnancy</td>
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<thead>
<tr>
<th>Psychosocial History</th>
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<tbody>
<tr>
<td>• Psychiatric and mental history</td>
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<tr>
<td>• H/o mood or anxiety disorders</td>
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<tr>
<td>• Mental illness/Medication or treatment for psychiatric mental disorders</td>
</tr>
<tr>
<td>• Supportive system: Husband/family and others/Stressors: Occupational or personal/Past history of depression or suicidal tendency</td>
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<tr>
<td>• Adjustment to circumstances</td>
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<tr>
<td>• /Emotional changes/History of any domestic violence</td>
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<tr>
<th>Family History</th>
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<tbody>
<tr>
<td>Health status of Parents/ siblings (if deceased , mention cause of death)/</td>
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<tr>
<td>H/o the diseases in Parents/ siblings/Close</td>
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</tbody>
</table>
relatives such as: Diabetes mellitus/Hypertension/Heart disease/Tuberculosis/Congenital disease/Renal disease/Asthma/Cancer/Vascular diseases/Neuromuscular condition/Multiple pregnancy/Complication of pregnancies/Psychiatric disorder

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<tr>
<th>Physical Assessment</th>
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<tr>
<th>Nutritional Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pallor/Oedema Arm muscle circumference Skin fold thickness Dietary Pattern</td>
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</table>

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<tr>
<th>Breast Examination</th>
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<tbody>
<tr>
<td>H/o breast surgery/mass/cyst/tumour/Observation of the breast/Scars/Skin condition and textures/Size of breasts/Nipple retraction/Discharge from nipple/H/o Breast implants/Lymph nodes palpable–Supracavicular region/Axillary region</td>
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</table>

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<thead>
<tr>
<th>Abdominal Examination</th>
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</thead>
<tbody>
<tr>
<td>Tenderness/Uterine involution Abdominal scars/ <strong>Visual Inspection</strong> - observe and record Scars / lesions /skin conditions <strong>Palpation</strong> – Palpate suprapubic, right iliac fossa and left iliac fossa regions and identify masses/Pain/Tenderness/guarding or rebound/Palpable lymph nodes in groin/External genitalia: Observe for Skin conditions or lesions/ Erythema/Excoriation/Distribution of pubic hair/Introital bleeding or discharge/Masses/prolapsed/Linear fissures/Foreign bodies (tampon or female condom) <strong>Type of discharge</strong>- amount, color and odor</td>
</tr>
</tbody>
</table>
**Vaginal examination:** Speculum examination
- Appearance of the vagina/inflammation
- Friability of tissue/foreign body/Discharge or visible lesions in the vagina

**Note:**
Vaginal Examination is required in case a woman complaint of itching and vaginal discharge (Not applicable to every woman)

**Observe the position and appearance of the cervix:** inflammation/color and consistency of any discharge/bleeding/cervical ectropion/lesions/ ulceration or polyps/presence or absence of contact bleeding/columnar epithelium on the ecto-cervix/Note the color, number and length of intrauterine device (IUCD) strings (if any present)
- Bimanual examination/Identify position of uterus – anteverted position/Retroverted position/Mid position

**Pelvic Floor Assessment**
- Pelvic floor tone assessment grade/Pelvic organ/prolapsed/
- Incontinence of urine/ stool

**Head to toe examination**
- Hair and scalp - healthy or infected
- Eyes - Color of conjunctiva, sclera, any discharge or signs of infection
- Ear, Nose and Throat - healthy, enlarged or signs of infection
- Mouth, gums and teeth - Hygiene, cavities or signs of infection
- Skin - any scar or sign of infection
- Extremities – Upper – check hand and colour and shape of nails
- Lower – any pain, tenderness, oedema or varicose veins
- Back and spine - observe for any deformity

**Investigations**

| Blood Count/Hemoglobin/ESR/WBC/TLC/DLC/Serum Cholesterol/ Lipid profile/Blood sugar/HIV Test/Urine for Pregnancy test/Urine for Albumin/Urine for sugar/Pap Smear/Mammography | |
Identification of High Risk Factors: ______________

Utilization of Health facility by women or Family members: ______________

Brief report of findings __________________________________________________________

Information regarding appropriate action (taken by you): __________________________________________________________

Health education given (Action Taken)

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
**Activity 25: Health Assessment of Women (15 to 45 years of age) (PSC/DH-2)**

Name of the Health Centre ________________________ Date : _______________

Date of Registration:_______ Registration No._______

**Identification Data:**

- **Name of the woman_______**
- **Name of the Husband (if applicable)_______**
- **Age_______**
- **Age_______**
- **Religion_______**
- **Education_______**
- **Occupation_______**
- **Occupation_______**
- **Marital Status ________**
- **Address_________**
- **Contact No._______**
- **Contact No._______**

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<thead>
<tr>
<th>Personal History</th>
<th>Findings</th>
<th>Management / Referral</th>
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(Attach additional sheets if required)

**Signature of the Academic Counselor/ Supervisor**
Activity 25: Health Assessment of Women (15 to 45 years of age)  (CHC-1)

Name of the Health Centre ________________________ Date : ______________

Date of Registration:_______ Registration No._______

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(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

303
Activity 25: Health Assessment of Women (15 to 45 years of age)  (CHC-2)

Name of the Health Centre ________________________ Date : ______________

Date of Registration:_______ Registration No._______

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Signature of the Academic Counselor/ Supervisor
Activity 25: Health Assessment of Women (15 to 45 years of age)  (PHC-1)

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Activity 25: Health Assessment of Women (15 to 45 years of age) (PHC-2)

Name of the Health Centre ________________________ Date : _______________

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Signature of the Academic Counselor/ Supervisor
Activity 25: Health Assessment of Women (15 to 45 years of age) (SC-1)

Name of the Health Centre ________________________ Date: ______________

Date of Registration:_______ Registration No._______

Identification Data:

Name of the woman_______ Name of the Husband (if applicable)_______
Age_______ Age_______
Religion_______ Education_______
Education_______ Occupation_______
Occupation_______ Contact No._______
Marital Status ________
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Contact No._______

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Signature of the Academic Counselor/ Supervisor
Activity 25: Health Assessment of Women (15 to 45 years of age)  (SC-2)

Name of the Health Centre ________________________ Date : ______________

Date of Registration:_______  Registration No._______

Identification Data:

Name of the woman_______  Name of the Husband (if applicable)_______
Age_______  Age_______
Religion_______  Education_______
Education_______  Occupation_______
Occupation_______  Contact No._______
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Address________
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(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor
Activity 26: Assessment and care of antenatal woman (PSC/DH-1)

Guidelines

- Select 2 antenatal mothers
- Take history in details.
- Assess for any health problems.
- Perform physical and abdominal examination
- Calculate Expected date of delivery (EDD)
- Give antenatal advices.
- Identify antenatal mother at risk and make appropriate referral.
- Record the findings.

ANTE NATAL CASE RECORD

Serial no……………………… Hospital identification no. ________________

Name______________________ Age_________ gravida __________________

Address ____________________ Para___________

________________________________ No. of Living children______________

________________________________ LMP___________________________

________________________________ EDD___________________________

Complaints________________________________________________________________________

____________________________________________________________________________________

History of present pregnancy

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<thead>
<tr>
<th>Trimester</th>
<th>Date</th>
<th>BP</th>
<th>Weight</th>
<th>Urine</th>
<th>Clinical findings</th>
<th>Remarks</th>
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<td>History taking</td>
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<td>Symptoms</td>
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<td>Obstetric History</td>
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<td>Any Current / Past Systemic Illnesses</td>
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<td>Abdominal Examination</td>
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<td>Health education / prenatal advice during pregnancy</td>
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<td>• Diet During Pregnancy</td>
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<td>• Smoking /Alcohol</td>
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<td>• Breast Care</td>
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<td>• Sexual Activities</td>
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(Attach additional sheets if required)
Activity 26: Assessment and care of antenatal woman  

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<td></td>
<td>No. of Living children</td>
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Signature of the Academic Counselor/Supervisor
Activity 26: Assessment and care of antenatal woman  

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Activity 26: Assessment and care of antenatal woman (CHC-2)

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Activity 26: Assessment and care of antenatal woman  (PHC-1)

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Signature of the Academic Counselor/Supervisor
Activity 26: Assessment and care of antenatal woman  (PHC-2)

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<th>Assessment</th>
<th>Findings</th>
<th>Management / Referral</th>
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<tr>
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<tr>
<td>Complaints</td>
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Signature of the Academic Counselor/Supervisor
Activity 26: Assessment and care of antenatal woman

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Name______________________ Age________ gravida ________________
Address ____________________ Para_____________
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Signature of the Academic Counselor/Supervisor
# Activity 26: Assessment and care of antenatal woman (SC-2)

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**Signature of the Academic Counselor/Supervisor**
Activity 27: Monitoring labour and maintaining partograph  (PSC/DH-1)

- Select 2 normal full term women
- Prepare delivery room
- Prepare equipments and accessories.
- Plot partographs of each woman and monitor
- Conduct PV examination
- Conduct normal delivery
- Record delivery notes.

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address_________
- k. Contact No._________

Pre-delivery preparation

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<th>Pre-delivery observation room criteria</th>
<th>Equipment and accessories</th>
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Preparation of delivery room:

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
PARTOGRAPH

Signature of the Academic Counselor/Supervisor
**Activity 27: Monitoring labour and maintaining partograph**  
(PSC/DH-2)

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age _______
- d. Religion _______
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Signature of the Academic Counselor/Supervisor
**Activity 27: Monitoring labour and maintaining partograph (CHC-1)**

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- b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
- c. Age _______
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Signature of the Academic Counselor/Supervisor
Activity 27: Monitoring labour and maintaining partograph (CHC-2)

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Signature of the Academic Counselor/Supervisor
### Activity 27: Monitoring labour and maintaining partograph (PHC-1)

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Activity 27: Monitoring labour and maintaining partograph  (PHC-2)

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Activity 27: Monitoring labour and maintaining partograph  (SC-1)

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Signature of the Academic Counselor/Supervisor
### Activity 27: Monitoring labour and maintaining partograph  (SC-2)

**Identification Data:**

- **a. Name:**
- **b. Relationship with head of family:** Self/Wife/son/daughter/any other
- **c. Age:**
- **d. Religion:**
- **e. Education:**
- **f. Occupation:**
- **g. Monthly income:**
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- **i. Marital Status:**
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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
Activity 28: Conducting Vaginal Examination  

(PSC/DH-1)

Guidelines:
- Select 2 cases of women in labor
- Conduct vaginal examination if required
- Take appropriate action
- Record the findings

VAGINAL EXAMINATION

Serial no……………………. Hospital identification no. _______________
Name______________________ Age__________ gravida _________________
Address____________________ Para_______________
____________________________________________________________________
No. of Living children______________
____________________________________________________________________
LMP__________________________
EDD___________________________

History of present pregnancy

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<tr>
<th>Trimester</th>
<th>Date</th>
<th>BP</th>
<th>Weight</th>
<th>Urine</th>
<th>Clinical Findings</th>
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Assessment/Examination | Findings | Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 28: Conducting Vaginal Examination (PSC/DH-2)

VAGINAL EXAMINATION

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Signature of the Academic Counselor/Supervisor
Activity 28: Conducting Vaginal Examination (CHC-1)

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(Hospital identification no. _______________
Name______________________
Age___________ gravida _______________
Address______________________
Para___________
No. of Living children____________
LMP______________________
EDD______________________

Signature of the Academic Counselor/Supervisor

(Attach additional sheets if required)
Activity 28: Conducting Vaginal Examination  (CHC-2)

VAGINAL EXAMINATION

Serial no. ..........................  Hospital identification no. ..........................
Name .................................  Age ............... gravida ..........................
Address ................................  Para ..........................
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Signature of the Academic Counselor/Supervisor
Activity 28: Conducting Vaginal Examination

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Signature of the Academic Counselor/Supervisor
## Activity 28: Conducting Vaginal Examination (PHC-2)

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**Signature of the Academic Counselor/Supervisor**
## Activity 28: Conducting Vaginal Examination

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Signature of the Academic Counselor/Supervisor
Activity 29: Conducting Episotomy

Guidelines:
- Select 2 cases who require episotomy
- Record the findings as per the procedure followed and your role in carrying out episiotomy.
- Provide post operative care and record.

EPISIOTOMY

Serial no……………………. Hospital identification no. _______________
Name______________________ Age_________ gravida _______________
Address ___________________ Para____________
_________________ No. of Living children____________
_________________ LMP____________________
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Complaints________________________________________________________________________
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History of present pregnancy

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PROCEDURE

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<th>Timing</th>
<th>Type of Episiotomy</th>
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<tbody>
<tr>
<td>Procedure</td>
<td>Postoperative care</td>
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Signature of the Academic Counselor/Supervisor
**Activity 29: Conducting Episotomy**  
(PSC/DH-2)

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Procedure

Postoperative care

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Signature of the Academic Counselor/Supervisor
Activity 29: Conducting Episotomy  

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Signature of the Academic Counselor/Supervisor
Activity 29: Conducting Episotomy  (CHC-2)

EPISIOTOMY

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**Activity 29: Conducting Episotomy**  

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Activity 29: Conducting Episotomy  

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Activity 29: Conducting Episotomy

EPISIOTOMY

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<td>Procedure</td>
<td>Postoperative care</td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 29: Conducting Episotomy (SC-2)

EPISIOTOMY

<table>
<thead>
<tr>
<th>Serial no.</th>
<th>Hospital identification no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Age</td>
</tr>
<tr>
<td>Address</td>
<td>Para</td>
</tr>
<tr>
<td></td>
<td>No. of Living children</td>
</tr>
<tr>
<td></td>
<td>LMP</td>
</tr>
<tr>
<td></td>
<td>EDD</td>
</tr>
<tr>
<td>Complaints</td>
<td></td>
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</table>

PROCEDURE

<table>
<thead>
<tr>
<th>Timing</th>
<th>Type of Episiotomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
<td>Postoperative care</td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 30: Care during various stages of labor

**Guidelines:**
- Select 2 cases of labor
- Monitor the women during labor
- Monitor every four hourly.
- Conduct delivery
- Take action during 3rd stage of labour.
- Provide Care of women during fourth stage of labour.
- Identify for abnormal signs and make appropriate referral

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age________
- d. Religion_______
- e. Education ______________
- f. Occupation________
- g. Monthly income_________
- h. Gender : Male/Female _________
- i. Marital Status ___________
- j. Address_________
- k. Contact No._________

**Patient Profile**

<table>
<thead>
<tr>
<th>Assessment and Care</th>
<th>Findings</th>
<th>Management/Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>First stage of labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second stage of labour</td>
<td></td>
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<tr>
<td>Stage of Labour</td>
<td></td>
<td></td>
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<tr>
<td>----------------</td>
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<tr>
<td>Third stage of labour (AMTL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fourth stage of labour (in labour room)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of women after delivery (postnatal ward)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate newborn care and assessment</td>
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<tr>
<td>Identify high risk cases</td>
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(Attach additional sheets if required)

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</table>

Signature of the Academic Counselor/Supervisor
### Activity 30: Care during various stages of labor  
(PSC/DH-2)

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age _______
- d. Religion _______
- e. Education __________
- f. Occupation _______
- g. Monthly income _______
- h. Gender: Male/Female _______
- i. Marital Status _______
- j. Address _______
- k. Contact No. _______

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<tr>
<th>Assessment and Care</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 30: Care during various stages of labor**

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other __________
- c. Age______
- d. Religion______  
- e. Education _________________
- f. Occupation______
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(Attach additional sheets if required)  

**Signature of the Academic Counselor/Supervisor**
Activity 30: Care during various stages of labor (CHC-2)

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age______
- d. Religion______
- e. Education ___________
- f. Occupation______
- g. Monthly income_________
- h. Gender: Male/Female __________
- i. Marital Status ___________
- j. Address_________
- k. Contact No._________

### Patient Profile

<table>
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<tr>
<th>Assessment and Care</th>
<th>Findings</th>
<th>Management/Referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 30: Care during various stages of labor**

**Identification Data:**
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
- c. Age______
- e. Education __________
- g. Monthly income__________
- i. Marital Status ________
- d. Religion______
- f. Occupation______
- h. Gender : Male/Female _______
- j. Address_________
- k. Contact No._______

**Patient Profile**

**Assessment and Care** | **Findings** | **Management/ Referral**
---|---|---

(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
### Activity 30: Care during various stages of labor  (PHC-2)

#### Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education _____________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status ___________
- j. Address_________
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#### Patient Profile

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<th>Findings</th>
<th>Management/ Referral</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 30: Care during various stages of labor  (SC-1)

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
d. Religion_______
e. Education _____________
f. Occupation_______
g. Monthly income___________
h. Gender :Male/Female ___________
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k. Contact No._______

<table>
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Signature of the Academic Counselor/Supervisor
Activity 30: Care during various stages of labor  

Identification Data:

a. Name ______
b. Relationship with head of family: Self/Wife/son/daughter/any other __________
c. Age ______
d. Religion ______
e. Education ______________
f. Occupation ______
g. Monthly income __________
h. Gender: Male/Female __________
i. Marital Status __________
j. Address __________
k. Contact No. __________

Patient Profile

<table>
<thead>
<tr>
<th>Assessment and Care</th>
<th>Findings</th>
<th>Management/Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care (PSC/DH-1)

Guidelines

- Select 2 women during Post Partum period
- Assess health status of woman after delivery and newborn baby
- Encourage mother to breast feed the newborn within one hour of delivery.
- Counsel the mother.
- Perform post natal visits
- Observe mother & baby.
- Maintain records & reports in logbook.

Serial no…………………… Hospital identification no. _______________

Name____________________ Age__________ gravida __________________

Address ____________________ Para_________________

No. of Living children__________

LMP____________________ EDD____________________

Date of Delivery__________________

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings `</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>History Taking Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/ Counselling</td>
<td></td>
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<tr>
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</tr>
<tr>
<td>Care for the Baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History taking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td></td>
<td></td>
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<tr>
<td>Management/ Counselling</td>
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<tr>
<td>Post Partum Counseling</td>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care

<table>
<thead>
<tr>
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<th>Hospital identification no.</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Age  gravida</td>
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<tr>
<td>Address</td>
<td>Para</td>
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<td></td>
<td>No. of Living children</td>
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<td>LMP</td>
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<td></td>
<td>EDD</td>
</tr>
<tr>
<td>Date of Delivery</td>
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</tbody>
</table>

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care

Serial no…………………….. Hospital identification no. _______________ 
Name _____________________ Age ________ gravida ________________
Address ____________________ Para ________________
________________________________ No. of Living children ____________
________________________________ LMP _________________
________________________________ EDD ___________________
Date of Delivery ______________

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings `</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care

Serial no……………………. Hospital identification no. ________________
Name______________________ Age________ gravida __________________
Address____________________ Para____________
No. of Living children____________
LMP______________________
EDD___________________________
Date of Delivery___________________

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care (PHC-1).

Serial no……………………. Hospital identification no._______________
Name______________________ Age__________ gravida ________________
Address_____________________ Para_____________
________________________________ No. of Living children______________
________________________________ LMP___________________
________________________________ EDD____________________
Date of Delivery_______________

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings `</th>
<th>Management/ Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

360
Activity 31: Post Partum Care (PHC-2).

Serial no……………………. Hospital identification no. _______________
Name______________________ Age________ gravida ______________
Address____________________ Para____________
________________________________ No. of Living children____________
________________________________ LMP____________________
________________________________ EDD____________________
Date of Delivery________________

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings `</th>
<th>Management/ Referral</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 31: Post Partum Care

Serial no. ……………………… Hospital identification no. ………………….
Name ……………………………… Age …… gravid ………………………
Address ………………………… Para ………………………
…………………………… No. of Living children ………………………
…………………………… LMP ………………………
…………………………… EDD ………………………
Date of Delivery ………………………

Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
### Activity 31: Post Partum Care

Serial no.………………… Hospital identification no.__________________
Name____________________ Age________ gravida __________________
Address___________________ Para____________ No. of Living children____________
______________________________ ____________________ LMP________________
______________________________ ____________________ EDD_____________________
Date of Delivery________________

#### Postpartum Visits

<table>
<thead>
<tr>
<th>Care of Mother</th>
<th>Findings `</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 32: Identification and management of complications during labor
(PSC/DH-1)

Guidelines:
- Select 2 mothers 15-45 years of age group
- Take history and perform assessment
- Give need based advices and prepare for follow up.
- Make appropriate referral depending upon the condition of the mother
- Record the action taken in logbook as per format given.

Name of the Health Facility ___________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age _______ d. Religion_______
- e. Education __________ e. Occupation_____ 
- g. Monthly income _________ h. Gender :Male/Female __________
- i. Marital Status __________ j. Address_________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/Referral</th>
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<tbody>
<tr>
<td>History of present illness</td>
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<tr>
<td>History of past medical illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family h/o medical illness</td>
<td></td>
<td></td>
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<tr>
<td>Obstetrical history</td>
<td></td>
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<tr>
<td>Anaemia</td>
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<tr>
<td>Antepartum Haemorrhage</td>
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<tr>
<td>Eclampsia</td>
<td></td>
<td></td>
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<tr>
<td>Obstructed labour</td>
<td></td>
<td></td>
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<tr>
<td>Cord Prolapse</td>
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<tr>
<td>Post Partum Haemorrhage</td>
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<tr>
<td>Obstetric Shock</td>
<td></td>
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<tr>
<td>Peuperial Sepsis</td>
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<tr>
<td>Premature Rutpurse of Membranes</td>
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<tr>
<td>Foetal Distress</td>
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<tr>
<td>Gestational Diabetes Mellitus (GDM)</td>
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<tr>
<td>Hypothyroidism</td>
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<tr>
<td>Syphilis</td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 32: Identification and management of complications during labor  
(PSC/DH-2)

<table>
<thead>
<tr>
<th>Name of the Health Facility</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Registration:</td>
<td>Registration No.:</td>
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</tbody>
</table>

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
- c. Age _______
- d. Religion _______
- e. Education _______
- f. Occupation _______
- g. Monthly income _______
- h. Gender: Male/Female _______
- i. Marital Status _______
- j. Address _______
- k. Contact No.: _______

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/Referral</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 32: Identification and management of complications during labor
(CHC-1)

Name of the Health Facility _____________________ Date: ________________

Date of Registration: _______ Registration No. ________

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age _______

d. Religion _______

e. Education ____________

f. Occupation _______

g. Monthly income _______

h. Gender : Male/Female ____________

i. Marital Status ____________

j. Address ____________

k. Contact No. _______

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/Referral</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 32: Identification and management of complications during labor**  
(CHC-2)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age______  
- d. Religion_____
- e. Education __________  
- f. Occupation____
- g. Monthly income__________  
- h. Gender: Male/Female _________
- i. Marital Status __________  
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<th>Findings</th>
<th>Management/Referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 32: Identification and management of complications during labor
(PHC-1)

Name of the Health Facility _____________________ Date: _______________

Date of Registration: _______ Registration No. _______

Identification Data:
   a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other _______
   c. Age _______
   d. Religion _______
   e. Education _______
   f. Occupation _______
   g. Monthly income _______
   h. Gender: Male/Female _______
   i. Marital Status _______
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   k. Contact No. _______

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<th>Assessment</th>
<th>Findings</th>
<th>Management/Referral</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

368
Activity 32: Identification and management of complications during labor  
(PHC-2)

Name of the Health Facility _____________________ Date: ________________
Date of Registration: _______ Registration No. _______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _______
  c. Age _______  d. Religion _______
  e. Education _______  f. Occupation _______
  g. Monthly income _______  h. Gender : Male/Female _______
  i. Marital Status _______  j. Address _______
  k. Contact No. _______

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<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
</table>

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Signature of the Academic Counselor/Supervisor
Activity 32: Identification and management of complications during labor

(SC-1)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _____________
  c. Age______
  d. Religion_______
  e. Education__________
  f. Occupation_____
  g. Monthly income__________
  h. Gender :Male/Female __________
  i. Marital Status __________
  j. Address__________
  k. Contact No.________

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<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/Referral</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 32: Identification and management of complications during labor**

(SC-2)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _________

c. Age__________

d. Religion__________

e. Education ____________

f. Occupation__________

g. Monthly income ________

h. Gender : Male/Female _________

i. Marital Status ____________

j. Address__________

k. Contact No. _______

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Findings</th>
<th>Management/ Referral</th>
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<tbody>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 33: Assessment and Management of STIs/RTIs

- Select 2 mothers/women
- Perform assessment
- Identify STIs/RTIs
- Take relevant history
- Make appropriate referral depending upon the condition.
- Give appropriate care and advice
- Record the action taken in logbook as per format given.

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education _____________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
- j. Address_________
- k. Contact No._______

History of present illness _________________________________________
History of past medical illness _______________________________________
Family h/o medical illness ___________________________________________

<table>
<thead>
<tr>
<th>Syndrome assessment</th>
<th>Findings</th>
<th>Management/ Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal discharge/ vaginal itching; dysuria (pain of urination); dyspareunia (pain during sexual intercourse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower abdominal Pain/ Vaginal discharge; lower abdominal tenderness or palpation; temperature &gt;38°C</td>
<td></td>
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<tr>
<td>Genital ulcer</td>
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<td></td>
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</tbody>
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Signature of the Academic Counselor/Supervisor
**Activity 33: Assessment and Management of STIs/RTIs**  
(PSC/DH-2)

Name of the Health Facility ___________________ Date: _____________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_____

d. Religion_______

e. Education _____________

f. Occupation_____

g. Monthly income _________

h. Gender : Male/Female _________

i. Marital Status ___________

j. Address _______

k. Contact No. _______

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<th>Syndrome assessment</th>
<th>Findings</th>
<th>Management/ Referral</th>
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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
Activity 33: Assessment and Management of STIs/RTIs (CHC-1)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. ________

Identification Data:
- a. Name ________
- b. Relationship with head of family: Self/Wife/son/daughter/any other __________
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Signature of the Academic Counselor/Supervisor
# Activity 33: Assessment and Management of STIs/RTIs (CHC-2)

Name of the Health Facility _____________________ Date: ______________ 
Date of Registration: _______ Registration No. ________

**Identification Data:**

a. Name ________  
b. Relationship with head of family: Self/Wife/son/daughter/any other ________________

c. Age______  
d. Religion_______

e. Education ________________  
f. Occupation______

g. Monthly income ____________  
h. Gender : Male/Female __________

i. Marital Status ___________  
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**Signature of the Academic Counselor/Supervisor**
**Activity 33: Assessment and Management of STIs/RTIs** (PHC-1)

Name of the Health Facility _____________________ Date:______________
Date of Registration:_______ Registration No.________

**Identification Data:**
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- **b. Relationship with head of family: Self/Wife/son/daughter/any other ___________**
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Signature of the Academic Counselor/Supervisor
**Activity 33: Assessment and Management of STIs/RTIs**  
**(PHC-2)**

Name of the Health Facility ___________________ Date: ______________

Date of Registration: _______  Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_______

d. Religion_______

e. Education __________

f. Occupation_____

g. Monthly income _________

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**Signature of the Academic Counselor/Supervisor**
Activity 33: Assessment and Management of STIs/RTIs

Name of the Health Facility _____________________ Date: ______________
Date of Registration: _______ Registration No. ____________

Identification Data:
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- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
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**Activity 33: Assessment and Management of STIs/RTIs**

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Signature of the Academic Counselor/Supervisor
Activity 34: Insertion and removal of IUDs (PSC/DH-1)

Select 2 eligible couple in need of IUDs services, do assessment
- Take relevant history and perform assessment
- Give appropriate care and need based advice
- Make appropriate referral depending upon the condition
- Record the action taken in logbook as per format given.

Name of the Health Facility as given below _____________________ Date: __________
Date of Registration: ______ Registration No. ______

Identification Data:
  a. Name ________
  b. Relationship with head of family: Self/Wife/son/daughter/any other ________
  c. Age ________
  d. Religion ________
  e. Education __________
  f. Occupation ________
  g. Monthly income __________
  h. Gender : Male/Female ________
  i. Marital Status __________
  j. Address __________
  k. Contact No. ________

History of present illness ______________________________
History of past medical illness _________________________
Family h/o medical illness __________________________

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Signature of the Academic Counselor/Supervisor
Activity 34: Insertion and removal of IUDs (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 34: Insertion and removal of IUDs  

Name of the Health Facility as given below __________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
- d. Religion_______
- e. Education ______________
- f. Occupation_______
- g. Monthly income __________
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Signature of the Academic Counselor/Supervisor
**Activity34: Insertion and removal of IUDs (CHC-2)**

Name of the Health Facility as given below ___________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_____

d. Religion_____

e. Education ___________

f. Occupation_____

g. Monthly income ___________

h. Gender : Male/Female _______

i. Marital Status ___________

j. Address_________

k. Contact No._______

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Signature of the Academic Counselor/Supervisor
Activity 34: Insertion and removal of IUDs  (PHC-1)

Name of the Health Facility as given below _____________________ Date:____________
Date of Registration:_______ Registration No._______

Identification Data:

a. Name _______
   b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
   c. Age______
   d. Religion______
   e. Education ______________
   f. Occupation_____
   g. Monthly income __________
   h. Gender: Male/Female __________
   i. Marital Status __________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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Activity 34: Insertion and removal of IUDs

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
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e. Education _____________
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Signature of the Academic Counselor/Supervisor
**Activity 34: Insertion and removal of IUDs**

**Name of the Health Facility as given below** _________________ **Date:** ________________

**Date of Registration:** _______ **Registration No.:** _______

**Identification Data:**

a. **Name:** _______
b. **Relationship with head of family:** Self/Wife/son/daughter/any other _______
c. **Age:** _______  
   d. **Religion:** _______
e. **Education:** _______  
   f. **Occupation:** _______
g. **Monthly income:** _______  
   h. **Gender:** Male/Female _______
i. **Marital Status:** _______  
   j. **Address:** _______
k. **Contact No.:** _______

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**Signature of the Academic Counselor/Supervisor**
Activity 34: Insertion and removal of IUDs (SC-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age______
  d. Religion______
  e. Education _____________
  f. Occupation_______
  g. Monthly income __________
  h. Gender :Male/Female _________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 35: Management of abortion and counseling  
(PSC/DH-1)

Guidelines:

- Select 2 women, do assessment who may require abortion
- Take relevant history and carry out assessment
- Give appropriate care/ counseling
- Record the action taken in logbook as per format given.
- Make appropriate referral depending upon the problem

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age__________
  d. Religion_______
  e. Education____________
  f. Occupation_______
  g. Monthly income__________
  h. Gender :Male/Female __________
  i. Marital Status ___________
  j. Address_________
  k. Contact No._______

History of present illness _________________________________________

History of past medical illness ________________________________

Family h/o medical illness _______________________________________

<table>
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<tr>
<th>Elements of Physical Examination</th>
<th>Findings</th>
<th>Action Taken</th>
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</thead>
<tbody>
<tr>
<td><strong>General Physical Examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General condition of the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital signs: Pulse Rate, Blood Pressure, Respiratory Rate Pallor/Cyanosis/Icterus/Pedal edema/Lymphadenopathy or Lymph node examination/clubbing Signs or marks of physical violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abdominal examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpate for the uterus, noting the size and whether tenderness is present. Note any other abdominal masses. Note any abdominal scars from previous surgery.</td>
<td></td>
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</tr>
<tr>
<td><strong>Pelvic examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examine the external genitalia for abnormalities or signs of disease or infection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speculum examination:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect the cervix and vaginal canal: look for abnormalities or foreign bodies;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
look for signs of infection, such as pus or other discharge from the cervical os; cervical cytology may be performed at this point, if indicated and available.

**Bimanual examination**
- Note the size, shape, position and mobility of the uterus.
- Assess for adnexal masses
- Assess for tenderness of the uterus on palpation or with motion of the cervix, and/or tenderness of the rectovaginal space (cul-de-sac), which may indicate infection.
- Confirm pregnancy and its duration

**Management and Appropriate referral if required**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 35: Management of abortion and counseling**

(PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**

d. Name _______

e. Relationship with head of family: Self/Wife/son/daughter/any other ________
f. Age_____ d. Religion______
e. Education _____________ f. Occupation_____
g. Monthly income ___________ h. Gender :Male/Female ________
i. Marital Status ____________ j. Address_________
j. Gender: Male/Female ______
k. Contact No._______

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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**

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Activity 35: Management of abortion and counseling  

**Name of the Health Facility as given below** _____________________ **Date:** __________________

**Date of Registration:** _______  
**Registration No.** _______

**Identification Data:**

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**Elements of Physical Examination**

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**Signature of the Academic Counselor/Supervisor**
Activity 35: Management of abortion and counseling  

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**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age________

d. Religion______

e. Education __________

f. Occupation______

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h. Gender : Male/Female __________

i. Marital Status __________

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Signature of the Academic Counselor/Supervisor
Activity 35: Management of abortion and counseling  (PHC-1)

Name of the Health Facility as given below _____________________ Date: ________________
Date of Registration: _______ Registration No. _________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other _____________
  c. Age_________ d. Religion_______
  e. Education ____________
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Signature of the Academic Counselor/Supervisor
Activity 35: Management of abortion and counseling  (PHC-2)

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: ________ Registration No. ________

Identification Data:
  a. Name ______
  b. Relationship with head of family: Self/Wife/son/daughter/any other __________
  c. Age ______
  d. Religion ______
  e. Education __________
  f. Occupation ______
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  h. Gender: Male/Female ________
  i. Marital Status __________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
# Activity 35: Management of abortion and counseling (SC-1)

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: ______  Registration No. ______

**Identification Data:**
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
- c. Age ______
- d. Religion ______
- e. Education ______
- f. Occupation ______
- g. Monthly income ______
- h. Gender: Male/Female ______
- i. Marital Status ______
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Signature of the Academic Counselor/Supervisor
Activity 35: Management of abortion and counseling  

Name of the Health Facility as given below _____________________ Date: ____________
Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age _______

d. Religion _______

e. Education ______________

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i. Marital Status ___________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 36: Adolescent Counseling

(PSC/DH-1)

Guidelines:

- Select 2 adolescent girls/boys
- Perform assessment and give appropriate care
- Identify problem
- Provide Adolescent Counseling
- Take relevant history
- Record the action taken in logbook as per format given.
- Make appropriate referral depending upon the problem

Name of the Health Facility as given below ________________ Date:______________

Date of Registration:________ Registration No.________

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

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d. Religion_______

e. Education ______________

f. Occupation_______

g. Monthly income __________

h. Gender :Male/Female __________

i. Marital Status ____________

j. Address_________

k. Contact No.________

Assessment | Findings | Management/ Referral

History of present illness

History of past medical illness

Family h/o medical illness

Management and Appropriate referral if required

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 36: Adolescent Counseling (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date: ________________
Date of Registration: _______  Registration No. ________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
- c. Age________
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- e. Education ____________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 36: Adolescent Counseling (CHC-1)

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _________

c. Age _______

d. Religion _______

e. Education _____________

f. Occupation _______

g. Monthly income _________

h. Gender : Male/Female _________

i. Marital Status _____________

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Signature of the Academic Counselor/Supervisor
**Activity 36: Adolescent Counseling**

Name of the Health Facility as given below _____________________ Date: ________________

Date of Registration: _______ Registration No. ________

**Identification Data:**
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Activity 36: Adolescent Counseling  

Name of the Health Facility as given below _________________ Date:________________

Date of Registration:_______ Registration No.________

Identification Data:

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Activity 36: Adolescent Counseling  

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Date of Registration:_______ Registration No._______  

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**Signature of the Academic Counselor/Supervisor**
Activity 37: Resuscitation of New Born

(PSC/DH-1)

Guidelines:
- Select 2 newborn babies who require resuscitation
- Prepare equipments required for resuscitation.
- Perform resuscitation as per steps explained
- Record in Logbook.

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______
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<tbody>
<tr>
<td>Prepare equipments used in resuscitation</td>
<td>Maintain Room Temperature</td>
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<tr>
<td>Equipments</td>
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<tr>
<td>• Suction equipments</td>
<td></td>
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<tr>
<td>• Bag and Mask</td>
<td></td>
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<tr>
<td>• Intubation</td>
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<tr>
<td>• Medication</td>
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<tr>
<td>• Miscellaneous</td>
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</table>

Follow the steps of resuscitation procedure:
- Routine care
- Initial steps
- Drying the baby
- Positioning
- Clear airway
  - When meconium is present and baby is vigorous
- Tactile stimulation
- Positive Pressure Ventilation (PPV)/
  - Indications

Refer:
Block: 6
Unit:1
BNSL-043
- Equipment available for PPV in newborns
- Position mask and obtain seal
- Assessing effectiveness of ventilation
- Observational care

**Chest compressions**
- Indications
- Positioning
- Technique
- Location
- Depth
- Rate
- Precautions

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 37: Resuscitation of New Born  

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 37: Resuscitation of New Born (CHC-1)

Name of the Health Facility ____________________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _______
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Signature of the Academic Counselor/Supervisor
Activity 37: Resuscitation of New Born  

Name of the Health Facility _____________________ Date:______________  

Date of Registration:_______ Registration No._______  

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Signature of the Academic Counselor/Supervisor
Activity 37: Resuscitation of New Born

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:

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Signature of the Academic Counselor/Supervisor
Activity 37: Resuscitation of New Born  (PHC-2)

Name of the Health Facility _____________________ Date:_________________

Date of Registration:_______ Registration No._______

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
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Activity 37: Resuscitation of New Born  

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Signature of the Academic Counselor/Supervisor
**Activity 37: Resuscitation of New Born**

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 38: Assessment of a Newborn Baby

(PSC/DH-1)

Guidelines:
- Select 2 newborn babies (pre-term/term/post term)
- Perform head to toe examination
- Identify abnormal signs & birth defects
- Take action appropriately and record in logbook.
- Make appropriate referral if required
- Provide need based health education

Name of the Health Facility _____________________ Date: _____________
Date of Registration: ___________ Registration No. ___________

Identification Data:
- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ______
- c. Age ______
- d. Religion_______
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- g. Monthly income ______
- h. Gender: Male/Female ______
- i. Marital Status ______
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Assessment of Gestational Age
- **Pre-term** (< 37 completed wks.)/
- **Term** (37 to 41 wks + 6 days) /
- **Post-term** (> 42 completed wks).

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<tbody>
<tr>
<td>Initial Assessment (observe and record)</td>
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**Identification of a preterm baby**
- Skin
- Hair and Lanugo:
- Ear Cartilage:
- Breast Nodule:
- Sole Creases:
- External Genitalia:
- Muscle tone:
- Joint mobility:
- Automatic reflexes:
**The fundus examination:**
### Assessment within first 24 hours
- Vital Signs

#### Physical Measurements
- Length:
- Weight:
- Head Circumference:
- Chest Circumference:

#### Head to toe assessment
- General behavior:
- Posture:
- Cry:
- Activity:
- Color:
- Skin:
- Head:
  - Hair
  - Shape
  - Size
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth and Throat:
- Sucking and rooting reflexes:
- Neck:
- Chest:
- Abdomen:
- Genitalia
  - Female Genitalia
  - Male Genitalia
- Anus:
- Back:
- Hips
- Extremities
**Neurological Assessment**
- Blinking or corneal reflex:
- Pupillary reflex:
- Doll’s eye:
- Glabellar reflex:
- Sneezing reflex:
- Sucking reflex:
- Rooting reflex:
- Gag reflex:
- Yawn reflex:
- Grasping reflex:
- Babinski reflex:
- Moros reflex:
- Startle reflex:
- Tonic neck Reflex:
- Dance or Step reflex:

**Examination for birth defects**
- Structural:
- Functional:
- Metabolic:
- Chromosomal:

**Assessment for appropriate follow up and referral**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 38: Assessment of a Newborn Baby

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

**Identification Data:**
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**Signature of the Academic Counselor/Supervisor**
Activity 38: Assessment of a Newborn Baby

Name of the Health Facility _____________________ Date: __________

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**Signature of the Academic Counselor/Supervisor**
Activity 38: Assessment of a Newborn Baby (CHC-2)

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
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Activity 38: Assessment of a Newborn Baby

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

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Signature of the Academic Counselor/Supervisor
Activity 38: Assessment of a Newborn Baby (PHC-2)

Name of the Health Facility _____________________ Date: __________

Date of Registration: _______ Registration No. _______

Identification Data:
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Signature of the Academic Counselor/Supervisor
Activity 38: Assessment of a Newborn Baby  

Name of the Health Facility _____________________ Date: ______________

Date of Registration: _______    Registration No. _______

Identification Data:

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Activity 38: Assessment of a Newborn Baby

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

423
Activity 39: Kangaroo Mother Care (KMC)  

(PSC/DH-1)

Guidelines:

- Select two babies who require KMC
- Provide Kangaroo Mother Care (KMC) as per guidelines
- Counsel the mother
- Record in the log book

**Name of the Health Facility** as given below ______________________ Date:____________

Date of Registration:_______ Registration No._______

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age__________
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**Assessment**

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<tbody>
<tr>
<td>History of past medical illness</td>
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<tr>
<td>History of present illness</td>
</tr>
<tr>
<td>Family h/o medical illness</td>
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<tr>
<td>Indicate for KMC</td>
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<tr>
<td>Record of Vital Signs</td>
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Signature of the Academic Counselor/Supervisor
Activity 39: Kangaroo Mother Care (KMC) (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:
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Signature of the Academic Counselor/Supervisor
Activity 39: Kangaroo Mother Care (KMC) (CHC-1)

Name of the Health Facility as given below _____________________ Date: ______________
Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______
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Signature of the Academic Counselor/Supervisor
Activity 39: Kangaroo Mother Care (KMC)  

(CHA-2)

Name of the Health Facility as given below ___________________ Date: __________

Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

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Assessment | Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 39: Kangaroo Mother Care (KMC)  

Name of the Health Facility as given below _____________________ Date:______________  
Date of Registration:_______ Registration No._______  

Identification Data:  
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Signature of the Academic Counselor/Supervisor
Activity 39: Kangaroo Mother Care (KMC)  

Name of the Health Facility as given below _____________________ Date: _____________

Date of Registration: _____ Registration No. _______

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _______
c. Age _______
d. Religion _______
e. Education _____________
f. Occupation _______
g. Monthly income _____________
h. Gender : Male/Female _______
i. Marital Status _____________
j. Address _____________
k. Contact No. _______

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<th>Assessment</th>
<th>Steps followed</th>
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<tbody>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

429
Activity 39: Kangaroo Mother Care (KMC)  

**Name of the Health Facility as given below** _____________________  **Date:** __________

**Date of Registration:** _______  **Registration No.** ________

**Identification Data:**

a. **Name** _______
b. **Relationship with head of family:** Self/Wife/son/daughter/any other _________
c. **Age** _______  
d. **Religion** _______
e. **Education** ___________

f. **Occupation** _______
g. **Monthly income** ___________

h. **Gender : Male/Female** ___________
i. **Marital Status** ___________

j. **Address** ___________
k. **Contact No.** _______

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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
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<th>Steps followed</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding  

(PSC/DH-1)

Guidelines:

Select 2 infants and children upto 2 years of age
- Assess the feeding
- Explain feeding recommendation
- Council the mother for breast feeding
- Identify any feeding problem

Name of the Health Facility as given below ________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age__________

d. Religion_______

e. Education________

f. Occupation_____

g. Monthly income_______

h. Gender :Male/Female __________

i. Marital Status __________

j. Address__________

k. Contact No._______

History of present illness

History of past medical illness

Family h/o medical illness

<table>
<thead>
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<th>Assessment</th>
<th>Findings</th>
<th>Management/ Referral</th>
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<tbody>
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<td>Assess type of feeding used by the infant and child</td>
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<tr>
<td>Assess the infant and child feeding problem</td>
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<tr>
<td>Feeding recommendation followed</td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding  (PSC/DH-2)

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______  Registration No.________

**Identification Data:**
  d. Name _______
  e. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  f. Age_______
  e. Education ______________
  f. Occupation________
  g. Monthly income __________
  h. Gender :Male/Female _________
  i. Marital Status ____________
  j. Address________
  k. Contact No._______

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<th>Assessment</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding  

Name of the Health Facility as given below _____________________ Date: ____________

Date of Registration: ____________ Registration No. ____________

Identification Data:

a. Name __________

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age __________

d. Religion __________

e. Education _____________

f. Occupation ____________

g. Monthly income ____________

h. Gender : Male/Female ____________

i. Marital Status ____________

j. Address ____________

k. Contact No. ____________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding (CHC-2)

Name of the Health Facility as given below _____________________ Date: ____________

Date of Registration: _______ Registration No. _______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age _______

d. Religion _______

e. Education _______

f. Occupation _______

g. Monthly income _______

h. Gender: Male/Female _______

i. Marital Status _______

j. Address _______

k. Contact No. _______

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<th>Findings</th>
<th>Management/Referral</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding (PHC-1)

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<td>Date of Registration:</td>
<td>Registration No.</td>
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</tbody>
</table>

**Identification Data:**

a. Name ________

b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age ________

d. Religion ________

e. Education ________

f. Occupation ________

g. Monthly income ________

h. Gender: Male/Female ________

i. Marital Status ________

j. Address ________

k. Contact No. ________

<table>
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<th>Assessment</th>
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<th>Management/Referral</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding  

Name of the Health Facility as given below _______________ Date: ______________

Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _________

c. Age _______

d. Religion _______

e. Education ________________

f. Occupation _______

g. Monthly income _________

h. Gender : Male/Female _______

i. Marital Status ___________

j. Address ___________

k. Contact No. _______

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<th>Assessment</th>
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Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  c. Age_______
  d. Religion_______
  e. Education _____________
  f. Occupation________
  g. Monthly income __________
  h. Gender :Male/Female ________
  i. Marital Status _____________
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  k. Contact No._______

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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 40: Infant and Young Child Feeding

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______  Registration No._______

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  c. Age______
  d. Religion_______
  e. Education ___________
  f. Occupation______
  g. Monthly income ____________
  h. Gender :Male/Female __________
  i. Marital Status ____________
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<th>Findings</th>
<th>Management/ Referral</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (PSC/DH-1)

Guidelines:
- Select two new born babies and two infants
- Assess breast feeding
- Counsel the mother for breast feeding
- Plot growth chart
- Select one child 5 years and above
- Assess the developmental Mile Stoned
- Record in the Log Book

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility __________________________ Date:_____________

Date of Registration:_______ Registration No.________

Identification Data:
  a. Name _______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ____________
  c. Age______
  d. Religion______
  e. Education____________
  f. Occupation______
  g. Monthly income________
  h. Gender :Male/Female __________
  i. Marital Status__________
  j. Address___________
  k. Contact No.__________

History of present illness

History of past medical illness

Family h/o medical illness

<table>
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<tr>
<th>Assessment</th>
<th>Developmental Mile Stones</th>
<th>Management</th>
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<tbody>
<tr>
<td>New born baby</td>
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<td>Assess breast feeding</td>
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<td>Positioning</td>
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<td>Counselling</td>
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<td><strong>Infant/ Toddlers</strong></td>
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<td>Height and Weight</td>
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<td>Head Circumference</td>
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<td>Chest Circumference</td>
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<td>Mid arm Circumference</td>
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<td><strong>Five years and above</strong></td>
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<tr>
<td>Developmental Mile Stones</td>
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<tr>
<td>Cognitive Milestones</td>
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<td>Motor Skills Milestones</td>
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<td>Social-Emotional Milestones</td>
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<td>Adaptive Milestones</td>
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(Attach additional sheets if required)

**Signature of the Academic Counselor/Supervisor**
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart  
(PSC/DH-2)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility _____________________ Date: ____________

Date of Registration: _______ Registration No. ______

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other _________
c. Age _______
d. Religion _______
e. Education ____________
f. Occupation _______
g. Monthly income ________
h. Gender: Male/Female ________
i. Marital Status ___________
j. Address ____________
k. Contact No. ________

Assessment Developmental Mile Stones Management

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (CHC-1)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility _____________________ Date: _________________

Date of Registration: _______ Registration No. _______

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _______
- c. Age _______
- d. Religion _______
- e. Education _______
- f. Occupation _______
- g. Monthly income _______
- h. Gender: Male/Female _______
- i. Marital Status _______
- j. Address _______
- k. Contact No. _______

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<th>Assessment</th>
<th>Developmental Milestones</th>
<th>Management</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (CHC-2)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility ___________________________ Date:________________

Date of Registration:_______ Registration No._______

Identification Data:

a. Name________
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age________
d. Religion_______
e. Education ______________
f. Occupation_______
g. Monthly income __________
h. Gender: Male/Female __________
i. Marital Status ____________
j. Address __________
k. Contact No._______

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<th>Developmental Milestones</th>
<th>Management</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (PHC-1)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name __________

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age________

d. Religion_______

e. Education __________

f. Occupation_______

g. Monthly income __________

h. Gender :Male/Female __________

i. Marital Status __________

j. Address________

k. Contact No._______

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<th>Developmental Milestones</th>
<th>Management</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (PHC-2)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility ___________________ Date:________________

Date of Registration:_______ Registration No._______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_______

d. Religion_______

e. Education______________

f. Occupation_______

g. Monthly income________

h. Gender :Male/Female _______

i. Marital Status______________

j. Address_________

k. Contact No._______

Assessment Developmental Milestones Management

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (SC-1)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility _____________________ Date:______________

Date of Registration:_________ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age______
d. Religion_______
e. Education ______________f. Occupation_____
g. Monthly income __________
h. Gender :Male/Female ___________
i. Marital Status ____________
j. Address_________
k. Contact No.________

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<th>Assessment</th>
<th>Developmental Milestones</th>
<th>Management</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 41: Promoting and Monitoring Growth and Development and Plotting Growth Chart (SC-2)

Please refer activity 3 for other details to complete this activity.

Name of the Health Facility _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  a. Name_______
  b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
  c. Age_______
  d. Religion_______
  e. Education _____________
  f. Occupation__________
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<th>Management</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices (PSC/DH-1)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below __________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ___________

c. Age______

d. Religion_____

e. Education ____________

f. Occupation______
g. Monthly income _________

h. Gender :Male/Female _________
i. Marital Status ____________

j. Address_________

k. Contact No._______

History of present illness………………………………………………………………………

History of past medical illness …………………………………………………………………

Family h/o medical illness……………………………………………………………………

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<th>Activity</th>
<th>Findings</th>
<th>Action Taken</th>
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<tbody>
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<td>Types of Immunization given to the child</td>
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<tr>
<td>Steps of Safe Injection Practices followed during Immunization</td>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices (PSC/DH-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______  
b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age________  
d. Religion______

e. Education________  
f. Occupation_______

g. Monthly income_________  
h. Gender :Male/Female__________

i. Marital Status___________  
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k. Contact No.___________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No._______

**Identification Data:**

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age_______

d. Religion_______

e. Education____________

f. Occupation_______

g. Monthly income__________

h. Gender :Male/Female _______

i. Marital Status___________

j. Address___________

k. Contact No._______

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<th>Action Taken</th>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices (CHC-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No.________

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
d. Religion_______
e. Education __________
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Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education ____________
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices  

(PHC-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other ____________

c. Age_______

d. Religion_______

e. Education __________

f. Occupation_______

g. Monthly income __________

h. Gender :Male/Female ____________

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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 42: Immunization and safe injection practices

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No.________

**Identification Data:**
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation_______
- g. Monthly income __________
- h. Gender :Male/Female __________
- i. Marital Status __________
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<th>Findings</th>
<th>Action Taken</th>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

455
Activity 42: Immunization and safe injection practices (SC-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below __________________________ Date: ______________

Date of Registration: ______ Registration No. ________

**Identification Data:**

a. Name ________

b. Relationship with head of family: Self/Wife/son/daughter/any other ________

c. Age________

d. Religion_______

e. Education ____________

f. Occupation_______

g. Monthly income _________

h. Gender : Male/Female _________

i. Marital Status ____________

j. Address_________

k. Contact No. _______

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<th>Findings</th>
<th>Action Taken</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below __________________________ Date: ____________

Date of Registration: ____ Registration No. ________

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _________

c. Age________

d. Religion_______

e. Education _________

f. Occupation_______

g. Monthly income__________

h. Gender: Male/Female _________

i. Marital Status ____________

j. Address________

k. Contact No. _________

History of present illness ........................................................................................................

History of past medical illness ............................................................................................

Family h/o medical illness .................................................................................................

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps and Action Taken</th>
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<tr>
<td>Type of Equipments used</td>
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<tr>
<td>Indications</td>
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<tr>
<td>Identification and Functioning of the parts of various equipment used</td>
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<tr>
<td>Steps of Use</td>
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<td>Application</td>
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(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments

(PSC/DH-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:

a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
d. Religion_______
e. Education __________
f. Occupation_______
g. Monthly income________
h. Gender :Male/Female __________
i. Marital Status __________
j. Address________
k. Contact No._______

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps and Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments (CHC-1)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________
Date of Registration:_______ Registration No.________

Identification Data:
- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
- c. Age_______
- d. Religion_______
- e. Education ____________
- f. Occupation_______
- g. Monthly income_________
- h. Gender :Male/Female __________
- i. Marital Status_________
- j. Address_________
- k. Contact No._______

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<th>Activity</th>
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</tr>
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</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments (CHC-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below ________________ Date: ________________

Date of Registration: ______ Registration No. ______

**Identification Data:**

a. Name ______
b. Relationship with head of family: Self/Wife/son/daughter/any other ______
c. Age______
d. Religion______
e. Education __________
f. Occupation______
g. Monthly income__________
h. Gender: Male/Female ______
i. Marital Status ____________
j. Address__________
k. Contact No. ______

<table>
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<tr>
<th>Activity</th>
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</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
## Activity 43: Use of Equipments

(PHC-1)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

**Identification Data:**

- a. Name _______
- b. Relationship with head of family: Self/Wife/son/daughter/any other ________
- c. Age_______
- d. Religion_______
- e. Education __________
- f. Occupation_______
- g. Monthly income__________
- h. Gender: Male/Female ________
- i. Marital Status ____________
- j. Address__________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Activity</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

__________________________
Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments  
(PHC-2)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date:______________

Date of Registration:_______ Registration No._______

Identification Data:
  
a. Name _______
b. Relationship with head of family: Self/Wife/son/daughter/any other ___________
c. Age_______
d. Religion_______
e. Education ___________
f. Occupation_______
g. Monthly income__________
h. Gender :Male/Female _________
i. Marital Status ____________
j. Address_________
k. Contact No._______

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps and Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Activity 43: Use of Equipments (SC-1)

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date: ________________

Date of Registration: _______ Registration No. _______

Identification Data:

a. Name _______

b. Relationship with head of family: Self/Wife/son/daughter/any other _______

c. Age _______

d. Religion _______

e. Education _______

f. Occupation _______

g. Monthly income _______

h. Gender: Male/Female _______

i. Marital Status _______

j. Address _______

k. Contact No. _______

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps and Action Taken</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
**Activity 43: Use of Equipments**

Please refer activity 11 for other details to complete this activity.

Name of the Health Facility as given below _____________________ Date: __________

Date of Registration: ______  Registration No. ______

**Identification Data:**

- a. Name ______
- b. Relationship with head of family: Self/Wife/son/daughter/any other _________
- c. Age_______  d. Religion_______
- e. Education ____________  f. Occupation_______
- g. Monthly income_________  h. Gender: Male/Female ________
- i. Marital Status ____________  j. Address_________
- k. Contact No._______

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps and Action Taken</th>
</tr>
</thead>
</table>

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor
Appendix-1

Facilitywise distribution of Practical Experience

<table>
<thead>
<tr>
<th>S.No</th>
<th>District Hospital</th>
<th>Community Health Centre</th>
<th>Primary Health Centre</th>
<th>Sub Health Centre</th>
<th>Urban Primary Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Days</td>
<td>Hrs</td>
<td>Days</td>
<td>Hrs</td>
<td>Days</td>
</tr>
<tr>
<td>22</td>
<td>132</td>
<td>10</td>
<td>60</td>
<td>10</td>
<td>60</td>
</tr>
</tbody>
</table>
**Monitoring Proforma for PSC Counsellors**

Name of PSC ……………………………………………………………………………………….

Name of the Student ……………………………………………………………………………..

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Name of the Skill</th>
<th>Skill training complete (Put only a tick marks)*</th>
<th>Signature With date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>District Hospital</td>
<td>CHC</td>
</tr>
<tr>
<td>1)</td>
<td>Management of Common Communicable Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td>Management of Common Non-Communicable Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>Management of Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td>Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>Geriatric Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td>Eye Care and ENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td>Common Conditions and Emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8)</td>
<td>Care in Pregnancy – Maternal Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Put a tick mark in respective column for the skills completed in respective spells.*
### Monitoring Proforma for PSC Counselors

Name of PSC ……………………………………………………………………………………………………………………

Name of the Student ……………………………………………………………………………………………………………

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Name of the Skill</th>
<th>Skill training complete (Put only a tick marks)*</th>
<th>Signature With date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>District Hospital</td>
<td>CHC</td>
</tr>
<tr>
<td>9)</td>
<td>Neonatal and Infant Health (0 to 1 year of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10)</td>
<td>Child Health, Adolescent Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11)</td>
<td>Reproductive Health and Contraceptive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12)</td>
<td>Management of Common Illnesses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Put a tick mark in respective column for the skills completed in respective spells.

---

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Appendix-3

Indira Gandhi National Open University
Certificate in Community Health for Nurses (BPCCHN) Programme

Attendance Certificate of Completion of Practical Training

Contact Session - DH

This is to certify that Mr. / Ms………………………………………………………………………
Enrolment Number…………………has maintained full attendance (100%) in practical training
session.
Name & Address of the PSC……………………………………………………………………………
                                                                                           .................................................................

Signature of Programme In-charge

Contact Session - CHC

This is to certify that Mr. / Ms………………………………………………………………………
Enrolment Number…………………has maintained full attendance (100%) in practical training
session.
Name & Address of the PSC……………………………………………………………………………
                                                                                           .................................................................

Signature of Programme In-charge

Contact Session - PHC

This is to certify that Mr. / Ms………………………………………………………………………
Enrolment Number…………………has maintained full attendance (100%) in practical training
session.
Name & Address of the PSC……………………………………………………………………………
                                                                                           .................................................................

Signature of Programme In-charge

Contact Session - SC

This is to certify that Mr. / Ms………………………………………………………………………
Enrolment Number…………………has maintained full attendance (100%) in practical training
session.
Name & Address of the PSC……………………………………………………………………………
                                                                                           .................................................................

Signature of Programme In-charge

Contact Session - UHC

This is to certify that Mr. / Ms………………………………………………………………………
Enrolment Number…………………has maintained full attendance (100%) in practical training
session.
Name & Address of the PSC……………………………………………………………………………
                                                                                           .................................................................

Signature of Programme In-charge

To

Regional Director,
IGNOU
Address of the Concern Regional Director’s office
Certificate of Eligibility for Term-End Examination (Practical only)

May for June Examination

Please read the instruction in the Programme guide before filling up this form

Indira Gandhi National Open University, New Delhi

Term-End Examination (Practical Only) December, 201...

CONTROL No. (For Office Use Only)

Programme Study
Centre Code
Enrolment No.
Write in BLOCK CAPITAL LETTERS only
NAME : ………………………………………………………

Details of the course in which practical examination has to be conducted.

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Course Title</th>
<th>Course Code</th>
<th>Intend to Take Examination (put** mark)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Public Health and Primary Care Skills</td>
<td>BNSL043</td>
<td></td>
</tr>
</tbody>
</table>

I hereby solemnly affirm that I have submitted the required number of Log-books/Project Report and have completed all the skills planned under the above course. The certificate of completion in support of the skills is attached.

I am aware that completion of all the skills at DH/CHC/PHC/UHC/SC and submission of Log-book is a prerequisite for taking Term-end(Practical) Examination. In case my above statement regarding submission is found to be untrue, the University may cancel the result of my abovementioned Practical Examination and I undertake, that I shall have no claim whatsoever in this regard. I also undertake that I shall abide by the decision, rules and regulations of the University. I have signed this undertaking on this ………………… Day of …………………. 201……….. .

Name …………………… Signature of Student………………...

Complete Address for Correspondence………………………………………………………………………………………………………………..

I have verified that the student has submitted all the Log-books and certificate of completion of skill related to the above course in time.

Place ………………… (Signature of Programme-in-charge with Stamp)

Date……………….
**Pattern of Practical Evaluation**

**Practical examination**

There will be one internal and one external examiner for the Practical examination. 10 students will be evaluated in one day. Candidate needs to score 50% marks in Term End Examination to be declared successful.

The marking scheme and other details of the practical evaluation is given below:

<table>
<thead>
<tr>
<th>Course</th>
<th>Item</th>
<th>Duration</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>BNSL-043</td>
<td>1 Long case – Pregnant women/any case (NCD)</td>
<td>40 minutes</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>History taking x 10 marks</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Physical examination x 10 marks</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Care and counseling x 5 marks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Short case</td>
<td>20 minutes</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Newborn/ child brief history and examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling and Health Education (General)</td>
<td>10 minutes</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Common ailments fever, aches and pain etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Viva (will be conducted by one internal and one external examiner)</td>
<td>30 minutes</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total marks</strong></td>
<td></td>
<td><strong>100 minutes</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>