Indira Gandhi National Open University
SCHOOL OF HEALTH SCIENCE

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, there after 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

List of Activities (BPCCHN) Programme

Activity 1	Community Assessment and Identification of Common Health Problems
Activity 2	Health Assessment of an individual
Activity 3	Nutritional Assessment and assessment of nutritional deficiencies
Activity 4	Organizing and Conducting Special Clinics
Activity 5	Investigation of an Outbreak
Activity 6	Identification and appropriate management of communicable diseases
Activity 7	Identification and appropriate management of Non-communicable Diseases (NCD)
Activity 8	Social Mobilization Skills
Activity 9	Health Education/Counseling
Activity 10	Recording and Reporting Format
Activity 11	Hand Washing Skills
Activity 12	Bio-medical Waste Management
Activity 13	Procedures for basic tests
Activity 14	Drugs dispensing and injections: oral drugs/ injections/ IV Fluid
Activity 15	Examination of Lumps and joint pain
Activity 16	Assessment of the patient with eye problems
Activity 17	Assessment of patients with Ear, Nose and Throat (ENT) problems
Activity 18	Identification and management of Dental problems
Activity 19	Suturing of superficial Wounds
Activity 20	Basic Life Support
Activity 21	Identification and care of patients with common conditions and emergencies
Activity 22	Aches and Pain
Activity 23	Common Fevers
Activity 24	Assessment and care of health problems among elderly
Activity 25	Health Assessment of Women (15 to 45 years of age)
Activity 26	Assessment and care of antenatal woman
Activity 27	Monitoring labour and maintaining partograph
Activity 28	Conducting Vaginal Examination
Activity 29	Conducting Episotomy
Activity 30	Care during various stages of labor
Activity 31	Post Partum Care
Activity 32	Identification and management of complications during labor
Activity 33	Assessment and Management of STIs/RTIs
Activity 34	Insertion and removal of IUDs
Activity 35	Management of abortion and counseling
Activity 36	Adolescent Counseling
Activity 37	Resuscitation of New Born
Activity 38	Assessment of a Newborn Baby
Activity 39	Kangaroo Mother Care (KMC)
Activity 40	Infant and Young Child Feeding
Activity 41	Promoting and Monitoring Growth and Development and Plotting Chart

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 acquinted 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 last 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 counselor 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

Activity 1	Community Assessment and Identification of Common Health Problems	community/field
Activity 2	Health Assessment of an individual	community/family/field
Activity 3	Nutritional Assessment and assessment of nutritional deficiencies	community/family/field
Activity 4	Organizing and Conducting Special Clinics	District Health/SC
Activity 5	Investigation of an Outbreak	Community Health Centre/ District Health
Activity 6	Identification and appropriate management of communicable diseases	Outpatient/Inpatient/community/family/field
Activity 7	Identification and appropriate management	Outpatient/Inpatient/community/family/field

	of Non-communicable Diseases (NCD)	
Activity 8	Social Mobilization Skills	community/field visit
Activity 9	Health Education/Counseling	Outpatient/Inpatient/community/family/field
Activity 10	Recording and Reporting Format	Outpatient/Inpatient/community Health Centre /family/field
Activity 11	Hand Washing Skills	Outpatient/Inpatient/community/family/field
Activity 12	Bio-medical Waste Management	Inpatient departments and sub-centre
Activity 13	Procedures for basic tests	Outpatient/Inpatient/community/family/field visit/clinics
Activity 14	Drugs dispensing and injections: oral drugs/ injections/ IV Fluid	Outpatient/Inpatient/community/family/field/SC
Activity 15	Examination of Lumps	Outpatient/Inpatient/community/family/field visit/SC/Clinics
Activity 16	Assessment of the patient with eye pain	Outpatient/Inpatient/community/family/field visit/SC/Clinics
Activity 17	Assessment of the patient with Ear, Nose and Throat (ENT) problems	Outpatient/Inpatient/community/family/field visit/SC/Clinics
Activity 18	Identification and management of Dental problems	Outpatient/Inpatient/community/family/field/Clinics
Activity 19	Suturing of superficial Wounds	Outpatient/Inpatient/SC
Activity 20	Basic Life Support	Outpatient/Inpatient/community/family/field Visit
Activity 21	Identification and care of patients with common conditions and emergencies	Outpatient/Inpatient/community/family/field/SC
Activity 22	Aches and Pain	Outpatient/Inpatient/community/family/field visit / SC
Activity 23	Common Fevers	Outpatient/Inpatient/community/family/field visit / SC
Activity 24	Assessment and care of health problems among elderly	Outpatient/Inpatient/community/family/field
Activity 25	Health Assessment of Women (15 to 45 years of age)	Outpatient/Inpatient/community/family/field visit / SC
Activity 26	Assessment and care of	Outpatient/community/family/field visit / SC

	antenatal woman	
Activity 27	Monitoring labour and maintaining partograph	Inpatient department /SC
Activity 28	Conducting Vaginal Examination	Outpatient/Inpatient/community/family/field visit / SC
Activity 29	Conducting Episotomy	Inpatient Department
Activity 30	Care during various stages of labor	Inpatient Department
Activity 31	Post Partum Care	Outpatient/Inpatient/community/family/field
Activity 32	Identification and management of complications during labor	Outpatient/Inpatient/community/family/field
Activity 33	Assessment and Management of STIs/RTIs	Outpatient/Inpatient/community/family/field
Activity 34	Insertion and removal of IUDs	Outpatient/Inpatient/Health Centre
Activity 35	Management of abortion and counseling	Outpatient/Inpatient/Health Centre
Activity 36	Adolescent Counseling	Outpatient/Inpatient/community/family/field visit
Activity 37	Resuscitation of New Born	Inpatient Department
Activity 38	Assessment of a Newborn Baby	Inpatient Department
Activity 39	Kangaroo Mother Care (KMC)	Outpatient/Inpatient/community/family/field visit
Activity 40	Infant and Young Child Feeding	Outpatient/Inpatient/community/family/field visit
Activity 41	Promoting and Monitoring Growth and Development and Plotting Chart	Outpatient/Inpatient/community/family/field visit
Activity 42	Immunization and safe injection practices	Under five clinic/community/family/field visit
Activity 43	Use of Equipments	Health Facility

1.4 MINIMUM NUMBER OF CASES TO BE SEEN FOR EACH SKILL

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

Skill	Place of Posting and Number of Cases				
	DH (Minimum)	**CHC (Minimum)**	**PHC (Minimum)**	**SC (Minimum)**	**USC Minimum)**
Activity 1: Community Assessment (CNA) and Identification of Common Health Problems	1	1	1	1	
Activity 2: Health Assessment of an individual	2	5	3	2	P
Activity 3*:* Nutritional Assessment and assessment of nutritional deficiencies	2	5	3	2	R E
Activity 4: Organizing and Conducting Special Clinics	1	5	2	2	S
Activity 5 : Investigation of an Outbreak	1	5	2	2	E
Activity 6: Identification and appropriate management of communicable diseases	2	5	2	2	N T
Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)	2	5	1	1	A T
Activity 8: Social Mobilization Skills	2	5	1	1	I
Activity 9: Health Education/Counselling	2	5	5	2	O
Activity 10: Recording and Reporting Format	2	5	3	2	N
Activity 11: Hand Washing Skills	2	5	3	2	
Activity 12: Bio-medical Waste Management	2	5	3	2	
Activity 13*:* Procedures for basic tests	2	5	3	2	O
Activity 14: Drugs dispensing and injections oral drugs/ injections/ IV Fluid	2	5	3	2	F
Activity 15: Examination of Lumps	2	5	3	2	
Activity 16:Assessment of patient with eye problems	2	5	3	2	
Activity 17: Assessment of patient with Ear, Nose and Throat (ENT) problems	2 Each	5	3	2	B R
Activity 18*:* Identification and management of Dental problems.	2	5	5	2	I
Activity 19: Suturing of superficial Wounds	2 each	1 each	5	2	E F
Activity 20*:* Basic Life Support.	2	5	3	2	
Activity 21*:* Identification and care of patients with common conditions and emergencies	2	5	3	2	
Activity 22: Aches and Pain	2	5	3	2	R E
Activity 23: Common Fevers	2	5	3	2	P
Activity 24: Assessment and care of health problems among elderly	2	5	3	1	O R

Activity 25: Health Assessment of Women (15 to 45 years of age)	2	5	3	1	T
Activity 26: Assessment and care of antenatal woman	2	5	3	1	
Activity 27: Monitoring labour and maintaining partograph	2	2	2		
Activity 28: Conducting Vaginal Examination	2	5	3	2	
Activity 29: Conducting Episotomy	2	5	3	2	
Activity 30: Care during various stages of labor					
Activity 31: Post Partum Care	2	5	3	2	
Activity 32: Identification and management of complications during labor	2	5	3	2	
	2	5	3	2	
Activity 33: Assessment and Management of STIs/RTIs	2	5	3	2	
Activity 34: Insertion and removal of IUDs	2	5	3	2	
Activity 35: Management of abortion and counseling	2	5	3	2	
Activity 36: Adolescent Counseling	2	5	3	2	
Activity 37*:* Resuscitation of New Born	2	5	3	2	
Activity 38:Assessment of a Newborn Baby	2	5	3	2	
Activity 39*:* Kangaroo Mother Care (KMC)					
Activity 40*:* Infant and Young Child Feeding	2	5	3	2	
Activity41: Promoting and Monitoring Growth and Development and Plotting Chart	2	5	3	2	
Activity 42: Immunization and safe injection practices	2	5	3	2	
Activity 43: Use of Equipments	2	5	3	2	

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:

Health Facilities	**No. of cases and marks**		**Total cases and Marks**
	Case-1	**Case-2**	
District Hospital (DH)	6	6	12
Community Health Centre (CHC)	4	4	8
Maintenance of Log Book			5
Total			**25**

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)

Sl.No.	Department	Name of the Counselor	Date of Posting		Signature of the Counselor
			From	To	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Community Health Centre (CHC)

Sl.No.	Department	Name of the Counselor	Date of Posting		Signature of the Counselor
			From	To	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Primary Health Centre (PHC)

Sl.No.	Department	Name of the Counselor	Date of Posting		Signature of the Counselor
			From	To	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Urban Health Centre (UHC)

Sl.No.	Department	Name of the Counselor	Date of Posting		Signature of the Counselor
			From	To	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Sub Centre (SC)

Sl.No.	Department	Name of the Counselor	Date of Posting		Signature of the Counselor
			From	To	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

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

Refer:
Block: 1
Unit: 1/Sec 1.2.1 1/1.3
BNSL-043

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

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

	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.	
3	**Primary health centre (PHC) level/ CHC level/ SC level**	Services and supplies	
4	**Identifying Health Indicators**	**Mortality indicators** • Crude death rate • Age specific death rates: • Infant mortality rate: • Child mortality rate: • Maternal mortality rate: • Case fatality rate **Morbidity indicators** • Incidence and prevalence rate • Notification rates • Admission, re-admission rates and discharge rates. • Out-patient department (OPD) attendance **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, weight for height, 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.	

5	**Social and environmental determinants of health**	**Determinants of Health (Ask from ANM and Record whichever applicable)** • Age • Gender • Genetics • Race, ethnicity • Literacy status • Nutrition • Environment • Socio-economic status • Socio-cultural conditions • Other factors	

(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_____
e. Education _____
g. Monthly income _____
i.Marital Status _____
d. Religion_____
f. Occupation_____
h. Gender :Male/Female _____
j. Address_____
k. Contact No._____

S.No	Areas	Activities	Findings

(Attach additional sheets if required)

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 _____
f. Occupation_____
g. Monthly income _____
h. Gender :Male/Female _____
i.Marital Status _____
j. Address_____
k. Contact No._____

S.No	Areas	Activities	Findings

(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)

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

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)

S.No	Areas	Activities	Findings

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

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._____

(Attached additional sheets if required)

S.No	Areas	Activities	Findings

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity -1: Community Assessment and Identification of Common Health Problems (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 _____
i.Marital Status _____ j. Address_____
k. Contact No._____

S.No	Areas	Activities	Findings

(Attach additional sheets if required)

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: _____
c.Age_____ d. Religion_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i.Marital Status _____ j. Address_____
k. Contact No._____

S.No	Areas	Activities	Findings

(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

Refer:
Block: 1
Unit: 1
BNSL-043 and
Block: 2
Unit: 2
BNSL – 043

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

Personal History	**Findings**	**Management/Report**
• **Habits**: Smoking/ alcohol Drug/ Tobacco/ Excessive tea or coffee • **Diet**: Vegetarian/ Non vegetarian/ egg vegetarian • **Life style**: Sedentary/ exercise/ relaxation/ Yoga/ meditation/ any other • **Hobbies**: _____ • **Hygiene**: Good/ Fair/ poor • **Rest and sleep:** adequate / inadequate • **Elimination habits**: Bowel: Good/ Fair/ Poor • **Bladder**: Good/ fair/ Poor		
Personal Medical History		
• Childhood disease (Specify) • Immunization status (completed / not		

completed or any other • Allergies (Yes / No, if yes please specify) • History of illness		
Psychosocial History : (Ask and Record)		
• Any Mental illness in the family, specify. • **Supportive system:** Husband/ family and others • **Stressors:** Occupational or personal • Past history of depression or suicidal tendency Emotional changes Adjustment to circumstances • History of any domestic violence		
Family History		
• Health status of Parents/ siblings (if deceased , mention cause of death) • History of the following diseases in Parents/siblings/ Close relatives (specify) Diabetes mellitus/Hypertension/Heart disease/Stroke Congenital disease/Asthma/Cancer (specify)/Multiple pregnancy/ Complication of pregnancy		
Physical Assessment		
• Height • Weight • Body Mass Index • Blood Pressure • Vital signs: Temperature, Pulse, Respiration • Oral Examination Abrasion/Bruises /Ulceration/Oedema/Injury/Bad breath H/o smoking/ tobacco consumption Check for loose teeth/broken teeth/missing teeth/decayed teeth. • **Nutritional Assessment** Pallor/ vitamin deficiency/ mineral deficiency • **Abdominal examination** Tenderness /Abdominal scars / any lesions/ • Palpation – Palpate suprapubic, right iliac fossa and left iliac fossa regions and identify masses/Pain/Tenderness/ Palpable lymph nodes in groin		

• External genitalia : Observe for Skin conditions or lesions/Erythema /Excoriation/ Distribution of pubic hair/Introital bleeding or discharge/any other		
Head to toe examination (specify if any)		
• 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:		
• Complete Blood Count Hemoglobin/ESR/WBC/TLC/DLC/Serum Cholesterol/ Lipid profile/Blood sugar/HIV Test/Urine for Pregnancy test		

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._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 2: Health Assessment of an individual (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._____

Personal History	Findings	Management/Report

(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._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

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._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 2: Health Assessment of an individual (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._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 2: Health Assessment of an individual (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 _____
i.Marital Status _____ j. Address_____
k. Contact No._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 2: Health Assessment of an individual (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._____

Personal History	Findings	Management/Report

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 3*:* Nutritional Assessment and assessment of nutritional deficiencies (PSC/DH-1)

Guidelines:

Refer:
Block: 1
Unit: 1
BNSL-043

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._____

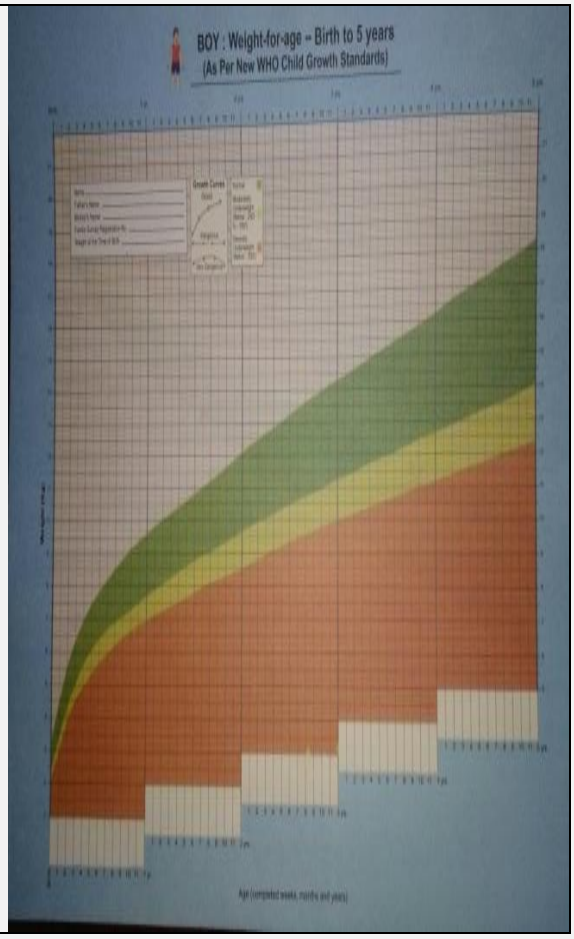
Identification Data:

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

Areas of Assessment	Findings	Management / Referal
History of present illness History of past medical illness /Family h/o medical illness Anthropometric Measurement Height Weight Chest circumference Mid Arm circumference Any other parameter Record the findings in (growth chart)		

Note: Fill up growth Chart



Assessment of Marasmus and Kwashiorkor, Vitamin and Mineral deficiency disorders

Marasmus	Findings	Action Taken
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 **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 hyper pigmentation)/hair changes (de-pigmentation, 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.		

	Findings	Action Taken
Vitamin A		
Reduced vision in the night or dim light/Dry eyes /Eye inflammation **Vitamin B_1** (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 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		
Vitamin B_2 (Riboflavin)		
Cheilosis (cracks in the lips)/High sensitivity to sunlight/ /Glossitis (inflammation of the tongue)/ Seborrheic dermatitis or pseudo syphilis (particularly affecting the scrotum or labia majora and the mouth/Pharyngitis (sore throat)/Edema of the pharyngeal or oral mucosa		
Vitamin B-3 (Niacin)		
Nausea/Abdominal cramps/Severe deficiency - mental confusion		
Vitamin B_6 (pyridoxine)		
Anemia/Skin disorders, such as a rash or cracks around the mouth./ Depression/Confusion/Pink eye/Epilepsy		
Vitamin B_9 (Folic Acid)		
Macrocytic anaemia/Birth defects		
Vitamin B_{12} (Cobalmin)		
Tingling in the feet and hands/Extreme fatigue/Weakness/ Irritability or depression/Memory Loss/Cognitive Defects		

Vitamin C		
Fatigue and lethargic/ Easy bruising/Bleeding and swollen gums/Slow wound healing/ inflammation of the gums/Dry and splitting hair/Dry red spots on the skin/Rough, dry, scaly skin/Nose bleeds/Swollen and painful joints./Possible weight gain because of slowed metabolism		
Vitamin D		
Severe asthma in children/Cancer		

Minerals Deficiency disorders	**Findings**	**Action Taken**
Anaemia Shortness of breath/Dizziness/Headache/Coldness in hands and feet/Pale skin/Chest pain/Weakness/Fatigue (Tiredness) **Calcium Deficiency** Muscle aches & cramps/Tooth Decay/Weak or deformed bones/brittle nails & dry skin/Heart Disease/Allergies/Chronic Arthritis/Headaches/ Common Colds, Flu, Infections. **Iodine or thyroid deficiency** 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		

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

Areas of Assessment	Findings	Management / Referal

(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

Areas of Assessment	Findings	Management / Referal

(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

Areas of Assessment	Findings	Management / Referal

(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

Areas of Assessment	Findings	Management / Referal

(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

Areas of Assessment	Findings	Management / Referal

(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 _____
i.Marital Status _____ j. Address_____
k. Contact No._____

Format for Nutritional Assessment and identification of Nutritional deficiencies

Areas of Assessment	Findings	Management / Referal

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 3*:* Nutritional Assessment and assessment of nutritional deficiencies (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._____

Format for Nutritional Assessment and identification of Nutritional deficiencies

Areas of Assessment	Findings	Management / Referal

(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

Refer:
Block: 1
Unit: 4
BNSL-043

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

Health Facility	Services
Sub centre	1. Health promotions for behavior change 2. "Opportunistic" Screening Using B.P measurement and blood glucose by strip method 3. Referral of suspected cases to CHC
CHC	1. Prevention and health promotion including counseling 2. Early diagnosis through clinical and laboratory investigations (Common lab investigations: Blood Sugar, lipid profile, ECG, Ultrasound, X ray etc.) 3. Management of common CVD, diabetes and stroke cases (out patient and in patients.) 4. Home based care for bed ridden chronic cases 5. Referral of difficult cases to District Hospital/higher health care facility.
District Hospital	1. Early diagnosis of diabetes, CVDs, Stroke and cancer 2. Investigations: • Blood Sugar,

	• lipid profile, • Kidney function Test (KFT), • Liver Function test (LFT), • ECG, Ultrasound, • X ray, • Colnoscopy, • 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

Format for Activities

District Hospital (DH)

S.No		Findings	Management/ Referral
1.	Opportunistic Screening		
2	Detailed Investigation		
3	Outsourcing of Certain Laboratory Investigations		

4	Out-patient and In-patient Care		
5	Day care Chemotherapy Facility	.	
6	Home based palliative care		
7	Referral & Transport facility to serious patients		
8	Health Promotion		
9	Training		
10	Data		

	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)

S.No		Findings	Management/ Referral
1.	Screening of NCD		
2	Prevention and health promotion		
3	Laboratory investigations	.	
4	Identification and Management		
5	Home based care		
6	Referral		

7	Data recording and reporting		
Primary Health Centre (PHC) and Sub-Centre (SC)			
S.No.	**Activity**	**Findings**	**Management/ Reports**
1	Home visits		
2	HWC/SC or Village (fixed day/week)		
3	Navigation services		
4	Document and record maintenance		
Format for activity at Family Planning Clinics			
S.No.	**Activity**	**Findings**	**Management /Referrals**
1	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		

	(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			
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**
History - present illness / Psychiatric and medical history / AOD / Psychosocial/Developmental History (Personal History) / Social History / Family History		
Comprehensive Assessment-/History /Psychosocial/developmental and personal history/Mental State/Cognitive Assessment/ Substance Use /Medical/Biological – physical assessment /Risk		
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		
Appearance and behavior/Hair and eye colour, ethnic origin, stature and posture./ grooming, hygiene, clothing		

Facial characteristics: furrowing of brow, tear-rimmed eyes facial expression and eye contact./ kempt or unkempt, personal hygiene standards (including body odour)		
General behaviour of the patient: disinhibition, psychomotor retardation, any sign of response to hallucinatory experiences.		
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 /I nability 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

	Findings	Action Taken
• Type of drug • Frequency of use • Average daily intake – no. injections/day • Duration of this episode, time and date of last use. • Signs and symptoms when you stop substance intake		

(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

Health Facility	Services

(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_____
g. Monthly income _____ h. Gender :Male/Female _____
j. Marital Status _____ j. Address_____
k. Contact No._____

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

Health Facility	Services

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 4: Organizing and Conducting Special Clinics (CHC-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 _____
k. Marital Status _____ j. Address_____
k. Contact No._____

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

Health Facility	Services

(Attach additional sheets if required)

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

Health Facility	Services

(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

Health Facility	Services

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 4: Organizing and Conducting Special Clinics (SC-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._____

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

Health Facility	Services

(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

Health Facility	Services

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 5 : Investigation of an Outbreak (PSC/DH-1)

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

Refer:
Block: 1
Unit: 3
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

Steps	Findings and Reporting
Ensure existence of outbreak	
Confirm Diagnosis with the help of authorised health professional	
Estimate the Number of Cases	
Analyse the data in terms of Time, Place and Person	
Determine who is at risk of contracting the disease	

Prepare Written Report	

Epidemiological Case Sheet

S.No.	Details	Findings	Management/Referral
1	Identification No.		
2	Date and time		
3	Name		
4	Age		
5	Sex		
6	Address: Residence, workplace separately		
7	Contact no:		
8	Symptoms present, Date and time of onset:		
9	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		

(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

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

(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

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

(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._____

Investigation of an outbreak

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

(Attach additional sheets if required)

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_____

k. Contact No._____

Investigation of an outbreak

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

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 5 : Investigation of an Outbreak (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._____

Investigation of an outbreak

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

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 5 : Investigation of an Outbreak (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 _____

i.Marital Status _____ j. Address_____

k. Contact No._____

Investigation of an outbreak

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

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 5 : Investigation of an Outbreak (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._____

Investigation of an outbreak

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

(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

Refer:
BNS-041
Block: 3
Unit: 1-4
BNSL-043
Block: 3
Unit: 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
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:**		

Fever/Splenomegaly and hepatomegaly/Anaemia/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_____
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 (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._____

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 (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._____

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._____

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-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

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 6: Identification and appropriate management of communicable diseases (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 _____
i.Marital Status _____ 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 (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

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD) (PSC/DH-1)

Refer:
BNS-041
Block: 1Unit:4
BNSL-043
Block: 1Unit:4

- 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_____ d. Religion_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i.Marital Status _____ j. Address_____
k. Contact No._____

Format for Risk Assessment

General Information			
History of present illness			
History of past medical illness			
Family h/o medical illness			
Part A: Risk Assessment			
Question	**Range**	**Finding**	**Write Score**
1. What is your age? (in complete years)	30-39 years		
	40-49 years		
	≥ 50 years		
2. Do u smoke or consume smokeless products such as Gutka; or Khaini?	Never		
	Used to consume in the past/ sometimes now		
	Daily		
3. Do you consume Alcohol daily?	No		

	Yes			
4. Measurement (Abdominal girth)	**Female**	**Male**		
	< 80 cm	< 90 cm		
	80-90 cm	90-100 cm		
	>90 cm	>100 cm		
5. Do you undertake any physical activities for minimum of 150 minutes in a weak?	Less than 150 minutes in a week			
	At least 150 minutes in a week			
6. Do u 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	**Findings**	**Management / Referral**
Shortness of breath		
Coughing more than 2 weeks		
Blood in sputum		
History of fits		
Difficulty in opening mouth		
Ulcers/patch/growth in the mouth that has not healed in two weeks		
Any change in the tone of your voice		
Women only		
Lump in the breast		
Blood stained discharge from the nipple		
Change in shape and size of breast		
Bleeding between periods		
Bleeding after menopause		
Bleeding after intercourse		
Foul smelling vaginal discharge		

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

NCDs	**Findings**	**Management / Referral**
Cardio Vascular Disease (CVD) **Coronary heart disease** Chest pain (angina) Sub sternal pressure radiating to neck, jaw, arm with duration <20-30 minutes which may be associated with dyspnea/ palpitations, nausea vomiting.		

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._____

Format for Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

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 Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

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:

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 Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)- (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._____

Format for Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

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 Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

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 Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 7: Identification and appropriate management of Non-communicable Diseases (NCD)- (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._____

Format for Assessment and Management of NCDs

NCDs	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 8: Social Mobilization Skills (PSC/DH-1)

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

Refer:
Block: 1
Unit: 5
BNSL-043

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._____

Guidelines	Findings	Management and Referral

Indentify 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		

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

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_____

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

i Marital Status _____ j. Address_____

k. Contact No._____

Guidelines	Findings	Management and Referral

(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._____

Guidelines	Findings	Management and Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 8: Social Mobilization Skills (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._____

Guidelines	Findings	Management and Referral

(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._____

Guidelines	Findings	Management and Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

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._____

Guidelines	Findings	Management and Referral

(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._____

Guidelines	Findings	Management and Referral

(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._____

Guidelines	Findings	Management and Referral

(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

Refer:
Block: 1
Unit: 6
BNSL-043

Prepare a plan of health education as per the need

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

S.No.	Objectives	Content	Teaching Learning Activity	Evaluation
1				
2				
3				

4				

(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

Place

Time Duration _____ to _____

Objectives	Content	Teaching Learning Activity	Evaluation

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

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/

Number of group members

Place

Time Duration _____ to _____

Objectives	Content	Teaching Learning Activity	Evaluation

(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 _____

Objectives	**Content**	**Teaching Learning Activity**	**Evaluation**

(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 _____

Objectives	Content	Teaching Learning Activity	Evaluation

(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 _____

Objectives	Content	Teaching Learning Activity	Evaluation

(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 _____

Objectives	Content	Teaching Learning Activity	Evaluation

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 9: Health Education/Counselling (SC -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 _____

Objectives	Content	Teaching Learning Activity	Evaluation

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 10: Recording and Reporting Format (PSC/DH-1)

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

Refer:
Block: 1
Unit: 7/Sec 7.2.2
BNSL-043

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.

Refer:
Block: 1
Unit: 3
BNSL-043

Name of the Health Centre _____ Date : _____

Draw Map in the space given

Village Register

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

Signature of the Academic Counselor/Supervisor

Household Survey Register

Refer:
Block: 1
Unit: 7/Sec 7.2.3
BNSL-043

S.No	Content/steps	Findings and Remarks
1	Number of eligible couples (ECs).	
2	Number of pregnant mothers.	
3	Number of pregnant mothers registered.	
4	Number of pregnant mothers registered given full doses of TT.	
5	Number of births.	
6	Number of births registered.	
7	Number of home deliveries.	
8	Number of home deliveries conducted by TBAs.	
9	Number of home deliveries conducted by ANM/ LHV.	
10	Number of deliveries conducted at PHCs/CHCs/ Govt. hospitals/nursing homes.	
11	Number of deliveries conducted by private practitioners.	
12	Number of pregnant mothers referred as high risk cases.	
13	Number of pregnant mothers who develop any kind of complication.	
14	Number of abnormal deliveries.	
15	Number of abortions.	
16	Number of low birth weight babies born.	
17	Number of newborns who had difficulty in breathing immediately after birth (did not cry immediately).	
18	Number of neonatal deaths occurred.	
19	Any stillborn baby delivered.	
20	Number of children upto one year of age.	
21	Number of children below 3 years of age.	
22	Number of children below 5 years of age.	
23	Number of children who have had frequent episode of diarrhea.	
24	Any children referred due to dehydration.	
25	Number of children who have had frequent attacks of ARI.	

26	Number of children referred to PHC/hospital for treatment of pneumonia.	
27	Number of children suffering from malnutrition.	
28	Number of children going to AW centre.	
29	Number of children completely or fully immunized. 0-1 year upto 3 years upto 5 years	
30	Number of women using oral pills. Women who have undergone MTP.	
31	Number of women who got Cu "T" inserted.	
32	Number of couples using condom.	
33	Number of women who had accepted sterilization (tubectomy).	
34	Number of men who have undergone vasectomy.	
35	Number of women who are having signs and symptoms of RTI/STI.	
36	Number of women/couples taking any treatment for RTI/STI.	
37	Number of adolescents – (i) Girls (10-19 years) (ii) Boys (10-19 years)	

Signature of the Academic Counselor/Supervisor

Eligible Couple Register

Refer:
Block: 1
Unit: 7/Sec 7.2.4
BNSL-043

S.No	Content/steps	Findings and Remarks
1	Identify number of couples	
2	Address	
3	Parity	
4	Age of youngest child	
5	Contraceptive method used	

Signature of the Academic Counselor/Supervisor

Cumulative Family Folder/Record

Refer:
Block: 1
Unit: 7/Sec 7.2.5
BNSL-043

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

Name of family member	Age / Sex	Rel. with HoF	Age at marr -iage	Edn	Occu- pation	Income	Ht	Wt	Any health problem

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

	Yes	No	Unique ID
Addiction			
Widow			
Delinquent behavior			
Unemployed			

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).

Contraceptive method used	Unique ID of EC	Duration of use	Satisfied	Not satisfied
Condom				
OCP				

Cu-T				
Vasectomy				
Tubectomy				

Note: Ask and record wherever applicable

Maternal Health and Contraception register

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

Refer:
Block: 1
Unit: 7/Sec 7.2.6
BNSL-043

S.No	Date	Name & Address	Complaints	Medicine given	Remarks

Signature of the Academic Counselor/Supervisor

Death Register

Refer:
Block: 1
Unit: 7/Sec 7.2.7
BNSL-043

S.No	Date of death	Name and address	Age	Sex	Cause of death

Signature of the Academic Counselor/Supervisor

Stock Register

Refer:
Block: 1
Unit: 7/Sec 7.2.8
BNSL-043

Drugs:

Date	Previous balance	Quantity received	Quantity used	Balance in hand	Expiry Date	Remarks

Inventory of Vaccines and Drugs

S. No	Item	Unit	Requirement assessed last year	Actual quantity received last year	Surplus of shortage last year	Requirement for current year
1	ORS packet					
2	Metronidazole tablets					
3	Cotrimoxazole					
4	Paracetemol					
5	Chloroquine					
6	Antiseptic solution					
7	Uristix					
8	DD kits (Disposable Delivery Kits)					
9	Thermameter					
10	Gloves					

11	IFA large tablets					
12	IFA small tablets					
13	Vitamin A solution					
14	Condom					
15	Oral Pills					
16	IUDs					
17	Syringe and needles					

Monthly Stock Position

S. No	Item	Opening balance	Recei-ved	Total	Consum-ption	Bala-nce	Require-ment
1	IFA large						
2	IFA small						
3	Vitamin A						
4	Cotrimoxozole						
5	ORS packets						
6	Methylergometrine						
7	Cholorophenaramine						
8	Paracetemol						
9	Anti-spasmodic tablets						
10	Inj Methylergometrine						
11	Mebendezole						
12	Syringes and needles						
13	Vaccine day carrier						
14	Steriliser Autoclave						
15	Choloramphemicol						

16	Centrimide powder						
17	Povidine ointment 5%						
18	Cotton bandage						
19	Contraceptives i) Nirodh ii) Oral pills iii) IUDs						
20	Disposable Delivery Kit						
21	Chloroquine Tablets						

Vaccine Received from PHC

S. No	Name of vaccine weekly session 1 Date/dose	Vaccine received for weekly session 2 Date/dose	Vaccine received for weekly session 3 Date/dose	Vaccine received for weekly session 4 Date/dose	Vaccine received for weekly	Vaccine received	Total
1	DPT						
2	OPV						
3	DT						
4	TT						
5	BCG						
6	Measles						
7	Pentavalent						

Signature of the Academic Counselor/Supervisor

Register for Recording Consultative Process

Refer:
Block: 1
Unit: 7/Sec 7.2.9
BNSL-043

Month/Year	Date & Time of holding the meeting	Venue/Place	Members who attended meeting	Items discussed
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Signature of the Academic Counselor/Supervisor

Referral Register

Refer:
Block: 1
Unit: 7/Sec 7.2.10
BNSL-043

Date	Name & Address	Age	Sex	Complaints	Reasons for Referral	Referred to	Follow-up actions taken

Signature of the Academic Counselor/Supervisor

Live Birth Report

Refer:
Block: 1
Unit: 7/Sec 7.2.11
BNSL-043

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 lvie 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

Serial No _____

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

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**

Death Report

Refer:
Block: 1
Unit: 7/Sec 7.2.13
BNSL-043

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

Town/Municipality _____

1. Date of death
2. Full name of the deceased
3. Place of death
4. Name of trhe 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) : _____

S. No	Services	Performance in correspond-ing month of last year	Performance in the reporting month	Cumulative performance till correspon-ding month of last year	Cumulative performance till current month	Planned performance in current month
1	**Antenatal Care**					
1.1	Antenatal Cases registered a) Total b) < 12 weeks					
1.2	No. of pregnant women who had 3 check-ups					
1.3	Total no. of high risk pregnant women referred					
1.4	No of TT Doses i) TT 1 ii) TT 2 iii) Booster					
1.5	No. of pregnant women under treatment for anaemia					
1.6	No. of pregnant					

	women given prophylaxis for anaemia										
2	**Natal Care**										
2.1	Total No. of deliveries										
2.2	Home Deliveries a)(i) 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										
6	**Pregnancy**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**

	Outcome										
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										
8	**Vitamin A administration (9 months to 3 years)**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
	Dose 1 Dose 2 Dose 3-5										
9	**Childhood Diseases**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
9.1	Vaccine preventable diseases a)Diphtheria i) Cases detected ii) Treated iii) Referred iv) Deaths b)Poliomyelitis (AFP) i) Cases detected ii) Treated iii) Referred iv) Deaths										
9.2	c)Neo Natal Tetanus i) Cases detected ii) Treated iii) Referred iv) Deaths d)Measles i) Cases detected ii) Treated iii) Referred iv) Deaths										
9.3	ARI under 5 years (Pneumonia) a) Treated with Cotrimoxozole b) Referred to PHC/FRU c) Deaths										

9.4	Acute Diarrhoeal Diseases under 5 years a) Treated with ORS b) Referred to PHC/FRU c)Deaths										
10	**Child Deaths**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
	a) Within 1 week b) 1 week - 1 month c) 1 month – 1 year d) 1 year – 5 years										
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										

11.6	Total Condom users					
12	Abortions a) No. of women referred for MTP b) No. of MTP done c) Cases followed up d) Deaths					

Date_____ Signature /thumb mark of the informant

Refer:
Block: 1
Unit: 7/Sec 7.2.15
BNSL-043

Daily Diary

Date	Activities performed in the field	Activities performed in the clinic

(Attach additional sheets if required)

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

Household Survey Register
Eligible Couple Register

Cumulative Family Folder/Record
Maternal Health and Contraception register

Sub-Centre/FRU Clinic Register
Death Register

Stock Register
Inventory of Vaccines and Drugs

Monthly Stock Position
Vaccine Received from PHC

Register for Recording Consultative Process
Referral Register

Live Birth Report
Still Birth Report

Death Report
Monthly Report for Sub-centre
Daily Diary

(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

Household Survey Register
Eligible Couple Register

Cumulative Family Folder/Record
Maternal Health and Contraception register

Sub-Centre/FRU Clinic Register
Death Register

Stock Register
Inventory of Vaccines and Drugs

Monthly Stock Position
Vaccine Received from PHC

Register for Recording Consultative Process
Referral Register

Live Birth Report

Still Birth Report

Death Report
Monthly Report for Sub-centre
Daily Diary

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 10: Recording and Reporting Format (SC)

Name of the Health Centre _____ Date : _____

Draw Map in the space given
Village Register

Household Survey Register
Eligible Couple Register

Cumulative Family Folder/Record
Maternal Health and Contraception register

Sub-Centre/FRU Clinic Register
Death Register

Stock Register
Inventory of Vaccines and Drugs

Monthly Stock Position
Vaccine Received from PHC

Register for Recording Consultative Process
Referral Register

Live Birth Report
Still Birth Report

Death Report
Monthly Report for Sub-centre
Daily Diary

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 11: Hand Washing Skills (PSC/DH-1)

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_____

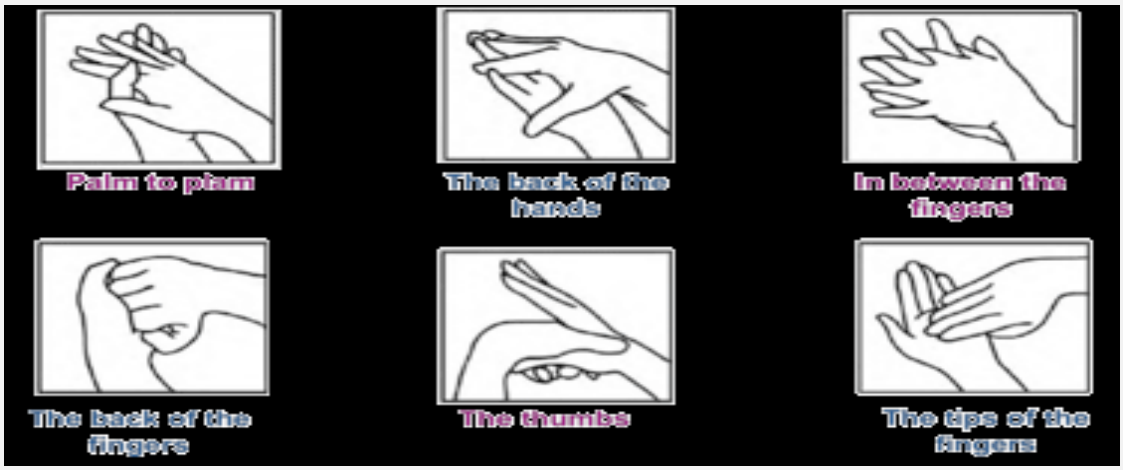
k. Contact No._____

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 (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._____

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 11: Hand Washing 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._____

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 11: Hand Washing 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._____

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 11: Hand Washing Skills (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 _____

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 (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._____

hand washing

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 12: Bio-medical Waste Management (PSC/DH-1)

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

- 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

Health Facility / Ward	Response		Remarks
Black bags	Yes	No	
Located at right place			
Placed on stand			
Contain only non-infected waste			
Is it torn?			
Available sufficiently			
Collected daily			
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				
House keeping				
Floor Hygiene	Good	OK	Poor	Bad
Toilets cleanliness	Good	OK	Poor	Bad

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 – CHC

Health Facility / Ward	Response		Remarks
Black bags	Yes	No	
Located at right place			
Placed on stand			
Contain only non-infected waste			
Is it torn?			
Available sufficiently			
Collected daily			
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				
House keeping				
Floor Hygiene	Good	OK	Poor	Bad
Toilets cleanliness	Good	OK	Poor	Bad

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

Health Facility / Ward	Response		Remarks
Black bags	Yes	No	
Located at right place			
Placed on stand			
Contain only non-infected waste			
Is it torn?			
Available sufficiently			
Collected daily			
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				
House keeping				
Floor Hygiene	Good	OK	Poor	Bad
Toilets cleanliness	Good	OK	Poor	Bad

General Comments: _____

Signature: _____

Signature of the Academic Counselor/ Supervisor

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

Check List for Bio-medical Waste Management – SC

Health Facility / Ward	Response		Remarks
Black bags	Yes	No	
Located at right place			
Placed on stand			
Contain only non-infected waste			
Is it torn?			
Available sufficiently			
Collected daily			
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				
House keeping				
Floor Hygiene	Good	OK	Poor	Bad
Toilets cleanliness	Good	OK	Poor	Bad

General Comments: _____

Signature: _____

Signature of the Academic Counselor/ Supervisor

Activity 12: Bio-medical Waste Management (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._____

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-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._____

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:

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 (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._____

Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 12: Bio-medical Waste Management (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._____

Check List for Bio-medical Waste Management

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 12: Bio-medical Waste Management (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 _____

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 (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._____

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)

Refer:
Block: 2
Unit: 2/Sec 2.3, 2.4, 2.5,2.6
Unit: 3
BNSL-043

Urine test for sugar albumin and pregnancy

Guidelines

- Select two patients /and two pregnant women who requires urine investgation
- 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 (Section3.4, 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._____

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 _____

S.No	Urine Tests	Reports and results
1		
2		
3		
4		
5		
S.No	Blood Tests	Reports and results
1		
2		
3		
4		
5		

S.No	**Collection of sample for Stool**	**Reports and results**
1		
S.No	**Collection of sample for Sputum**	**Reports and results**
1		

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (PSC/DH-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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 13*:* Procedures for basic tests (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._____

Urine Tests	Reports and results

(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

Refer:
Block: 2
Unit: 8/Sec 8.5
BNSL-043

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 _____

S.No	Method	Patient Profile	Drugs dispensed
1	Oral		
2			
3			
4			
5			
1	Injection		

2			
3			
4			
5			
1	**IV Fluids**		
2			
3			
4			
5			

(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 _____

i Marital Status _____ j. Address_____

k. Contact No._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

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_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i Marital Status _____ j. Address_____
k. Contact No._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

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_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i Marital Status _____ j. Address_____
k. Contact No._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

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 _____
c. Age_____ d. Religion_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i Marital Status _____ j. Address_____
k. Contact No._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

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 _____
c. Age_____ d. Religion_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i Marital Status _____ j. Address_____
k. Contact No._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

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 _____ f. Occupation_____

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

i Marital Status _____ j. Address_____

k. Contact No._____

Method	Patient Profile	Drugs dispensed

(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._____

Method	Patient Profile	Drugs dispensed

(Attach additional sheets if required)

Signature of the Academic Counselor /Supervisor

Activity 14: Drugs dispensing and injections: oral drugs, injection, IV Fluid (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._____

Method	Patient Profile	Drugs dispensed

(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

Refer:
Block: 2
Unit: 4
BNSL-043

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:

S.No.	Question	Findings	Management / Referral
1.	When was the lump first noticed? (Duration)		
2.	What made the patient notice the lump? (First symptom)		
3.	What are the symptoms related to the lump? (Other symptoms)		
4.	Has the lump changed in size, texture since it was first noticed? (Progression)		
5.	Does the lump ever disappear (persistence)? What makes the lump to reappear?		
6.	Has the patient ever had any other lumps? (Multiplicity)		
7.	What does the patient think caused the lump? (Cause)		
8.	Is there loss of bodyweight?		
9.	Is there recurrence after operation?		

Assessment and examination	Findings	Management / Referral
1. Look (observation) 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 **2. Feel the lump/swelling (palpation)** 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		

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 _____

History	Findings
a) Medical Disease related to Heart , Lungs, Abdomen, Diabetes or Chronic disease	
b) Surgical Disease or Trauma or Any surgery	
c) Dietary History	
d) History of Job /Sports	

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 1being 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 (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._____

:

Question	Findings	Management / Referral
Assessment of lumps		
Assessment of joint pain		

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Refer:
Block: 2
Unit:5
BNSL-043

- 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

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

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 (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._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

c.Age_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i Marital Status _____ j. Address_____

k. Contact No._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

c.Age_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i Marital Status _____ j. Address_____

k. Contact No._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

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._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i Marital Status _____ j. Address_____

k. Contact No._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 16: Assessment of the patient with eye problems (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._____

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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._____

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

Assessment	Findings	Management / Referral

(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-1)

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

Refer:
Block: 2
Unit:5
BNSL-043

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

Assessment	Findings	Management / Referral
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		

(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:

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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._____

Problem of Ear

Assessment	Findings	Management / Referral

(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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (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._____

Problem of Ear

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (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._____

Problem of Ear

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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 _____
j. Address_____
k. Contact No._____

Problem of Ear

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 17: Assessment of patients with Ear, Nose and Throat (ENT) problems (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._____

Problem of Ear

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 18*:* Identification and Management of Dental problems (PSC/DH-1)

Refer:
Block: 2
Unit: 6
BNSL-043

- 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_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management/ Referral
History of present illness History of past medical illness Family h/o medical illness Assess Problems		

(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

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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. 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

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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._____

Assessment and Management

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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 _____ j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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 _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management/ Referral

(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 _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management/ Referral

(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_____
d. Religion_____
e. Education _____
f. Occupation_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management/ Referral

(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

Refer:
Block: 2
Unit: 7
BNSL-043

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

Assessment	Findings	Management / Referral

(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_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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 _____
f. Occupation_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 19: Suturing of superficial Wounds (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._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 19: Suturing of superficial Wounds (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._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 19: Suturing of superficial Wounds (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._____

Assessment and Management

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 20*:* Basic Life Support (PSC/DH-1)

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

Refer:
Block: 3
Unit:1
BNSL-043

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	Findings	Management / Referral
Basic Life Support Steps:		

(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

Refer:
Block: 3
Unit:1
BNSL-043

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	Findings	Management / Referral
Basic Life Support Steps:		

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 20*:* Basic Life Support (PSC/DH-2)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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 20*:* Basic Life Support (CHC-1)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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 20*:* Basic Life Support (PHC-1)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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 20*:* Basic Life Support (PHC-2)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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 20*:* Basic Life Support (SC-1)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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 20*:* Basic Life Support (SC-2)

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

Date of Registration:_____ Registration No._____

Refer:
Block: 3
Unit:1
BNSL-043

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

Refer:
Block: 3
Unit: 2,3
BNSL-043

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

Assessment	Findings	Action Taken
Food Poisoning		
Acid Poisoning		
Alkali Poisoning		

Dog Bite		
Snake Bite		
Insect bites and stings		
Minor injury		
Burns and scalds		
Trauma (RTA)		
Drowning		
Seizure		

(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-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._____

Assessment	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 21*:* Identification and care of patients with common conditions and emergencies (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._____

Assessment	Findings	Action Taken

(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 _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Assessment	Findings	Action Taken

(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_____
g. Monthly income _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Assessment	Findings	Action Taken

(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_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Assessment	Findings	Action Taken

(Attach additional sheets if required)

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._____

Assessment	Findings	Action Taken

(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)

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	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (PSC/DH-1)

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

Refer:
Block: 3
Unit: 3
BNSL-043

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

History	**Findings**	**Management/ Referral**
a) Medical Disease related to Heart , Lungs, Abdomen, Diabetes or Chronic disease		
b) Surgical Disease or Trauma or Any surgery		
c) Menstrual History (for Women)		
d) Obstetrical History		
e) Dietary History		
f) History of Substance abuse		
g) Food allergies (if any)		
h) Medication history		

Physical Examination General examination • Pulse • BP • Respiration • Temperature • Levels of Consciousness		
Site of Pain (Upper/Lower , Quadrant affected , Possible organ affected , Centrally Located)		
Onset of pain (Before taking food , After taking food ,Sudden , Slow, Steady)		
Character of pain (Stabbing , Cramping , Burning, Dull ,Acute, Chronic , Colicky)		
Radiation of pain (Back, Chest , Over the abdomen , Localized)		
Associated Symptoms (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.		
Time Course of pain (Has become worse over the time , Has become better over the time , No change)		
Exacerbating /Relieving Symptoms (Position, Diarrhea /Passage of Stool/Urine, Coughing, Food, Medicines)		
Severity Rate the pain from 1-10 for 1being the slight pain and 10 being the worst pain		
Possible organ affected		
Findings on: • Inspection • Auscultation • Percussion • Palpation		
Possible problem of the patient:		
Advices and Referral details:		

Assessment of Chest Pain

Take History	**Findings**	**Management / Referral**
a) Medical Disease related to Heart , Lungs, Abdomen, Diabetes or Chronic disease		
b) Surgical Disease or Trauma or Any surgery		
c) Dietary History		
d) History of Substance abuse/Smoking		
e) Food allergies (if any)		
f) Medication history		
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 1being the slight pain and 10 being the worst pain		
Possible diagnosis of the problem:		

Assessment of Back Pain

History	Findings	Management / Referral
a) Medical Disease related to Heart , Lungs, Abdomen, Diabetes or Chronic disease		
b) Surgical Disease or Trauma or Any surgery		
c) Dietary History		
d) History of Job /Sports		
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 1being 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 (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._____

Assessment of Abdominal Pain

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

Assessment of Abdominal Pain

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

Assessment of Abdominal Pain

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

Assessment of Abdominal Pain

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 22: Aches and Pain (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._____

Assessment of Abdominal Pain

History	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (PSC/DH-1)

Guidelines:

Refer:
Block: 3
Unit: 2
BNSL-043

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

S.No	Signs and Symptoms	Yes	No	Management / Referral
1.	**Cardinal Signs and Symptoms**			
	High temperature - above 37°C (98. 6°F)			
	Pallor of skin			
	Feeling cold with shivering and chattering teeth			
	Hot, flushed skin, body rash and sweating			
	Headache			
	General body aches			
2	**Accompanying signs and symptoms**			
	Nausea, vomiting			
	Diarrhea			
	Cough			

	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 (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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (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._____

Signs and Symptoms	Findings	Management / Referral

(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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 23: Common Fevers (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._____

Signs and Symptoms	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 24: Assessment and care of health problems among elderly (PSC/DH-1)

Refer:
Block: 3
Unit: 6
BNSL-043

- 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

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral
Cataract /Glaucoma / Retinopathy			
Nerve deafness / Conductive hearing loss			
Fibrositis /Osteoarthritis/ Rheumatoid arthritis / Myositis /Neuritis/ Gout / Spondilitis of spine			

Dementia / Parkinsons disease / Alzheimer's disease			
Atherosclerosis/ Thrombus formation/ Myocardial Infarction, Hypertension			
Chronic bronchitis /Asthma / Emphysema			
Senile wrinkles / Scaly lesions / Scaly dermatosis / Blistering diseases /Neoplastic disorders			
Peptic ulcer / Constipation / Ulcerative colitis / Carcinoma of GIT			
Frequency and urgency of micturation / Nocturia / Dysuria / Enlargement of prostate			

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 24: Assessment and care of health problems among elderly

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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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._____

Assessment of Physical Problems	Findings	Action Taken	Appropriate referral

(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:

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 Physical Problems	Findings	Action Taken	Appropriate referral

(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:

Name of the woman_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral
• Habits: Smoking/ alcohol Drug/ Tobacco/ Excessive tea or coffee • Diet: Vegetarian/ Non vegetarian/ egg vegetarian • Life style: Sedentary/ exercise/ relaxation/ Yoga/ meditation/ any other • Hobbies • Hygiene: Good/ Fair/ poor • Rest and sleep (No. of hours at night _____ and day_____. • Elimination habits: Bowel: Good/ Fair/ Poor • Bladder: Good/ fair/ Poor		
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		
Menstrual History		
• Age at menarche • H/o menstrual cycle • duration/Date of last menstrual period (LMP)/ • Amount of blood flow • Any complaints like dysmenorrhoea		
Marital and Sexual History		
• Age at marriage • Duration of marriage • Duration of co-habilitation • Relationship with spouse • Sexually active/ inactive/ Contraceptive history and practice • History of presence of sexually transmitted disease (if any)/Type/Treatment		
Obstetrical History		
• Gravida/ Para/ Number of living children/ • H/o abortion/still birth /infant death/ • H/o previous pregnancies/deliveries/ • H/o any caesarean section/Any signs of present pregnancy		
Psychosocial History		
• Psychiatric and mental history • H/o mood or anxiety disorders • Mental illness/Medication or treatment for psychiatric mental disorders • Supportive system: Husband/family and others/Stressors: Occupational or personal/Past history of depression or suicidal tendency • Adjustment to circumstances • /Emotional changes/History of any domestic violence		
Family History		
Health status of Parents/ siblings (if deceased , mention cause of death)/ H/o the diseases in Parents/ siblings/Close		

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		
Physical Assessment		
Height/Weight/Body Mass Index /Blood Pressure/Vital signs: Temperature/Pulse/Respiration Oral Examination: Abrasion/Ulceration/Oedema/Bruises/Injury/Bad breadth/ H/o smoking/ tobacco consumption/Check for loose teeth/broken teeth/missing teeth/decayed teeth.		
Nutritional Assessment		
Pallor/Oedema Arm muscle circumference Skin fold thickness Dietary Pattern		
Breast Examination		
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		
Abdominal Examination		
Tenderness/Uterine involution Abdominal scars/ **Visual Inspection** - observe and record Scars / lesions /skin conditions **Palpation** – 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) **Type of discharge**- amount, color and odor		

Vaginal examination: Speculum examination observe- 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		
Complete 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_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(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._____

Identification Data:

Name of the woman_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

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._____

Identification Data:

Name of the woman_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 25: Health Assessment of Women (15 to 45 years of age) (PHC-1)

Name of the Health Centre _____Date : _____

Date of Registration:_____ Registration No._____

Identification Data:

Name of the woman_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

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

Name of the Health Centre _____Date : _____

Date of Registration:_____ Registration No._____

Identification Data:

Name of the woman_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

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_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

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_____
Age_____
Religion_____
Education_____
Occupation_____
Marital Status _____
Address_____
Contact No._____

Name of the Husband (if applicable)_____
Age_____
Education_____
Occupation_____
Contact No._____

Personal History	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/ Supervisor

Activity 26: Assessment and care of antenatal woman (PSC/DH-1)

Guidelines

Refer:
Block: 4
Unit: 1 and 2
BNSL-043

- 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

Trimester	Date	BP	Weight	Urine	Clinical findings	Remarks
First						
Second						
Third						

Assessment	Findings	Management / Referral
History taking		
Record of Ante Natal Card		
Symptoms		
Obstetric History		
Any Current / Past Systemic Illnesses		
Family History		
Personal history		

General Physical examination and measurements		
Abdominal Examination		
Laboratory Investigations		
Health education / prenatal advice during pregnancy • Diet During Pregnancy • Personal Hygiene • Care of Teeth • Rest and Sleep • Physical Work • Exercise • Comfortable Clothing and Shoes • Smoking /Alcohol • Breast Care • Drugs • Protections from Infections and Illnesses • Sexual Activities • Reporting of untoward Signs and Symptoms • Care of New Born Family Planning Methods and Counseling		

Antenatal Intervention		
Screening for complications such as • Toxemias of Pregnancy • Diabetes • Tetanus Protection • Rubella • HIV Screening • Hepatitis B • Syphilis • German Measles • Rh Status • Prenatal Genetic Screening		

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 26: Assessment and care of antenatal woman (PSC/DH-2)

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

Assessment	Findings	Management / Referral

(Attach additional sheets if required)

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.

Refer:
Block: 4
Unit:3-4
BNSL-043

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._____

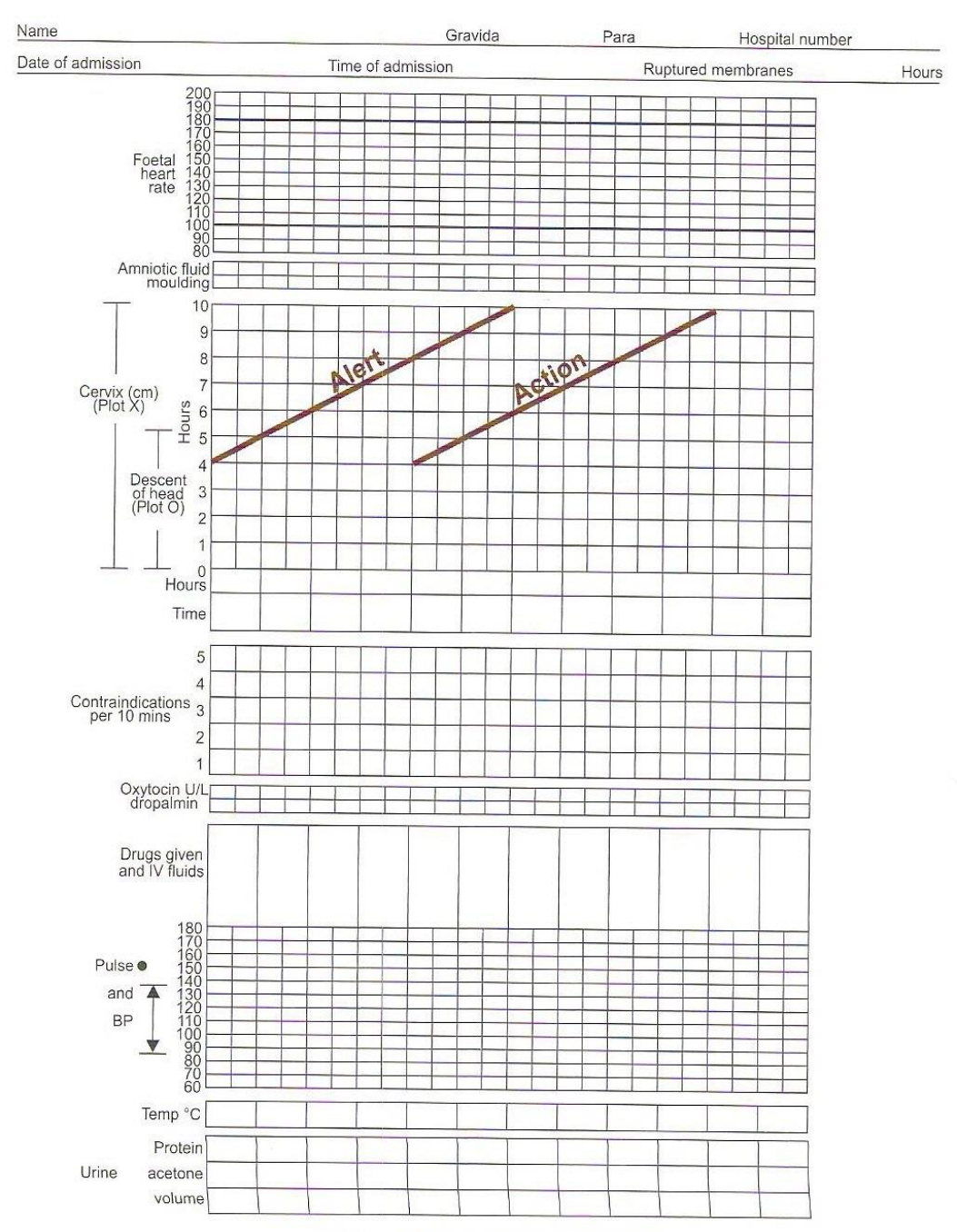
Pre-delivery preparation

Pre-delivery observation room criteria	Equipment and accessories
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_____

e. Education _____ f. Occupation_____

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

i. Marital Status _____ j. Address_____

k. Contact No._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 27: Monitoring labour and maintaining partograph (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._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 27: Monitoring labour and maintaining partograph (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._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 27: Monitoring labour and maintaining partograph (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._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 27: Monitoring labour and maintaining partograph (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._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 27: Monitoring labour and maintaining partograph (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 _____

i.Marital Status _____ j. Address_____

k. Contact No._____

Pre-delivery observation room criteria	Equipment and accessories

(Attach additional sheets if required)

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 _____ h. Gender :Male/Female _____

i Marital Status _____ j. Address_____

k. Contact No._____

Pre-delivery observation room criteria	Equipment and accessories

(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

Refer:
Block: 4
Unit: 4
BNSL-043

VAGINAL EXAMINATION

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

History of present pregnancy

Trimester	Date	BP	Weight	Urine	Clinical findings	Remarks
First						
Second						
Third						

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

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (CHC-1)

VAGINAL EXAMINATION

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (CHC-2)

VAGINAL EXAMINATION

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (PHC-1)

VAGINAL EXAMINATION

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (PHC-2)

VAGINAL EXAMINATION

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (SC-1)

VAGINAL EXAMINATION

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 28: Conducting Vaginal Examination (SC-2)

VAGINAL EXAMINATION

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Assessment/Examination	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (PSC/DH-1)

Refer:
Block: 4
Unit: 4
BNSL-043

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_____

_____

EDD_____

Complaints_____

_____

History of present pregnancy

Trimester	Date	BP	Weight	Urine	Clinical findings	Remarks
First						
Second						
Third						

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (PSC/DH-2)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (CHC-1)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (CHC-2)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (PHC-1)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (PHC-2)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (SC-1)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 29: Conducting Episotomy (SC-2)

EPISIOTOMY

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Complaints_____

_____

PROCEDURE

Timing	**Type of Episiotomy**
Procedure	**Postoperative care**

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 30: Care during various stages of labor (PSC/DH-1)

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

Refer:
Block: 4
Unit: 4,6
BNSL-043

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		
Assessment and Care	**Findings**	**Management/ Referral**
First stage of labour		
Second stage of labour		

Third stage of labour (AMTL)		
Fourth stage of labour (in labour room)		
Care of women after delivery (postnatal ward)		
Immediate newborn care and assessment		
Identify high risk cases		

(Attach additional sheets if required)

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._____

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 (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._____

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 (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

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-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._____

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_____

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 (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 _____

i.Marital Status _____ 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 (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._____

Patient Profile

Assessment and Care	Findings	Management/ Referral

(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.

Refer:
Block: 4
Unit:6
BNSL-043

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral
History Taking Mother		
Examination		

Management/ Counselling		
Care for the Baby		
History taking		
Examination		
Management/ Counselling		
Post Partum Counseling		

(Attach additional sheets if required)

.

Signature of the Academic Counselor/Supervisor

Activity 31: Post Partum Care (PSC/DH-2)

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 31: Post Partum Care (CHC-1)

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 31: Post Partum Care (CHC-2).

Serial no…….

Hospital identification no. _____

Name_____

Age_____ gravida _____

Address _____

Para_____

_____

No. of Living children_____

_____

LMP_____

_____

EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral

(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

Care of Mother	Findings `	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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

Care of Mother	Findings `	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 31: Post Partum Care (SC-1)

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 31: Post Partum Care (SC-2)

Serial no……. Hospital identification no. _____

Name_____ Age_____ gravida _____

Address _____ Para_____

_____ No. of Living children_____

_____ LMP_____

_____ EDD_____

Date of Delivery_____

Postpartum Visits

Care of Mother	Findings `	Management/ Referral

(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.

Refer:
Block: 4
Unit: 5
BNSL-043

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	Findings	Management/ Referral
History of present illness History of past medical illness Family h/o medical illness • Obstetrical history • Anaemia • Antepartum Haemorrhage • Eclampsia • Obstructed labour • Cord Prolapse • Post Partum Haemorrhage • Obstetric Shock • Peuperial Sepsis • Premature Rutpure of Membranes • Foetal Distress • Gestational Diabetes Mellitus (GDM) • Hypothyroidism • Syphilis		

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 32: Identification and management of complications during labor (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._____

Assessment	Findings	Management/ Referral

(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._____

Assessment	Findings	Management/ Referral

(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 _____ j. Address_____
k. Contact No._____

Assessment	Findings	Management/ Referral

(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 _____ j. Address_____
k. Contact No._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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._____

Assessment	Findings	Management/ Referral

(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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 33: Assessment and Management of STIs/RTIs (PSC/DH-1)

- 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.

Refer:
Block: 5
Unit:1
BNSL-043

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 _____

Syndrome assessment	Findings	Management/ Referral
Vaginal discharge/ vaginal itching; dysuria (pain of urination); dyspareunia (pain during sexual intercourse)		
Lower abdominal Pain/ Vaginal discharge; lower abdominal tenderness or palpation; temperature >38°C		
Genital ulcer		

(Attach additional sheets if required)

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._____

Syndrome assessment	Findings	Management/ Referral

(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 _____
c. Age_____
d. Religion_____
e. Education _____
f. Occupation_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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 _____
j. Address_____
k. Contact No._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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:

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._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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 _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 33: Assessment and Management of STIs/RTIs (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._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 33: Assessment and Management of STIs/RTIs (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._____

Syndrome assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: 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.

Refer:
Block: 5
Unit:2
BNSL-043

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 _____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: 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 _____

c.Age_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i.Marital Status _____ j. Address_____

k. Contact No._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: Insertion and removal of IUDs (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._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

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._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: 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 _____
j. Address_____
k. Contact No._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: Insertion and removal of IUDs (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._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: Insertion and removal of IUDs (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._____

Types of IUDs used	Steps followed	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity34: 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 _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Types of IUDs used	Steps followed	Management / Referral

(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

Refer:
Block: 5
Unit:3
BNSL-043

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 _____

Elements of Physical Examination	Findings	Action Taken
General Physical Examination General condition of the patient 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		
Abdominal examination Palpate for the uterus, noting the size and whether tenderness is present. Note any other abdominal masses. Note any abdominal scars from previous surgery.		
Pelvic examination Examine the external genitalia for abnormalities or signs of disease or infection. **Speculum examination:** Inspect the cervix and vaginal canal: look for abnormalities or foreign bodies;		

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_____
e. Education _____
g. Monthly income _____
i. Marital Status _____
d. Religion_____
f. Occupation_____
h. Gender :Male/Female _____
j. Address_____
k. Contact No._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 35: Management of abortion and 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 _____ j. Address_____
k. Contact No._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 35: Management of abortion and counseling (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._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

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 _____
f. Occupation_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

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_____
g. Monthly income _____
h. Gender :Male/Female _____
i. Marital Status _____
j. Address_____
k. Contact No._____

Elements of Physical Examination	Findings	Action Taken

(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 _____
j. Address_____
k. Contact No._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 35: Management of abortion and counseling (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._____

Elements of Physical Examination	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 36: Adolescent Counseling (PSC/DH-1)

Guidelines:

Refer:
Block: 5
Unit:4
BNSL-043

- 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 _____
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
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_____ 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 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 _____ j. Address_____
k. Contact No._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 36: Adolescent Counseling (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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 36: Adolescent 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 _____ 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 36: Adolescent 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_____
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 36: Adolescent 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 _____
j. Address_____
k. Contact No._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 36: Adolescent Counseling (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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

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.

Refer:
Block: 6
Unit:1
BNSL-043

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._____

Guidelines	Findings	Management / Referral
Prepare equipments used in resuscitation Maintain Room Temperature **Equipments** • Suction equipments • Bag and Mask • Intubation • Medication • Miscellaneous		
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		

- 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 (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._____

Guidelines	Findings	Management / Referral

(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 _____

c. Age_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i. Marital Status _____ j. Address_____

k. Contact No._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 37*:* Resuscitation of New Born (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._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 37*:* Resuscitation of New Born (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._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

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 _____

c. Age_____ d. Religion_____

e. Education _____ f. Occupation_____

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

i. Marital Status _____ j. Address_____

k. Contact No._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 37*:* Resuscitation of New Born (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._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 37*:* Resuscitation of New Born (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._____

Guidelines	Findings	Management / Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 38:Assessment of a Newborn Baby (PSC/DH-1)

Guidelines:

Refer:
Block: 6
Unit: 2
BNSL-043

- Select 2 new born 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_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Assessment of Gestational Age	**Findings**	**Management/ Referral**
• **Pre-term** (< 37 completed wks,) / • **Term** (37 to 41wks+6 days) / • **Post-term** (> 42 completed wks).		
Initial Assessment (observe and record)		
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 (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._____

Assessment of Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 38:Assessment of a Newborn Baby (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._____

Assessment of Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

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 _____
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 Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 38:Assessment of a Newborn Baby (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._____

Assessment of Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

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:

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 Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 38:Assessment of a Newborn Baby (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._____

Assessment of Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 38:Assessment of a Newborn Baby (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._____

Assessment of Gestational Age	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (PSC/DH-1)

Guidelines:

Refer:
Block: 6
Unit: 3
BNSL-043

- 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_____ d. Religion_____
e. Education _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Assessment	Steps followed
History of past medical illness	
History of present illness	
Family h/o medical illness	
Indicate for KMC	
Record of Vital Signs	

(Attach additional sheets if required)

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:

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	Steps followed

(Attach additional sheets if required)

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 _____
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	Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (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._____

Assessment	Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (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	Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (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._____

Assessment	Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (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._____

Assessment	Steps followed

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 39*:* Kangaroo Mother Care (KMC) (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._____

Assessment	Steps followed

(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

Refer:
Block: 6
Unit: 4
BNSL-043

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	Findings	Management/ Referral
Assess type of feeding used by the infant and child Assess the infant and child feeding problem Feeding recommendation followed		

(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 _____

g. Monthly income _____

i. Marital Status _____

d. Religion_____

f. Occupation_____

h. Gender :Male/Female _____

j. Address_____

k. Contact No._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 40: Infant and Young Child Feeding (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._____

Assessment	Findings	Management/ Referral

(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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 40: Infant and Young Child Feeding (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	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 40: Infant and Young Child Feeding (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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 40: Infant and Young Child Feeding (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._____

Assessment	Findings	Management/ Referral

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 40: Infant and Young Child Feeding (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._____

Assessment	Findings	Management/ Referral

(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:

Refer:
Block: 6
Unit: 5
BNSL-043

- 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 Stones
- 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

Assessment	Developmental Mile Stones	Management
New born baby Assess breast feeding Positioning Attachment		

Counselling **Infant/ Toddlers** Height and Weight Head Circumference Chest Circumference Mid arm Circumference **Five years and above** Developmental Mile Stones Cognitive Milestones Motor Skills Milestones Social-Emotional Milestones Adaptive Milestones		

(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._____

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-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 (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._____

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 (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 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 (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._____

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 (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_____
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 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._____

Refer:
Block: 6
Unit: 6
BNSL-043

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……

Activity	Findings	Action Taken
Types of Immunization given to the child		
Steps of Safe Injection Practices followed during Immunization		

(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 _____ j. Address_____
k. Contact No._____

Activity	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 42: Immunization and safe injection practices (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._____

Activity	Findings	Action Taken

(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 _____ f. Occupation_____
g. Monthly income _____ h. Gender :Male/Female _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Activity	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 42: Immunization and safe injection practices (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._____

Activity	Findings	Action Taken

(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 _____
i. Marital Status _____ j. Address_____
k. Contact No._____

Activity	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 42: Immunization and safe injection practices (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._____

Activity	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

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._____

Activity	Findings	Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 43: Use of Equipments (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._____

Refer:
Block: 6
Unit: 7
BNSL-043

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……

Activity	Steps and Action Taken
Type of Equipments used	
Indications	
Identification and Functioning of the parts of various equipment used	
Steps of Use	
Application	

(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._____

Activity	Steps and Action Taken

(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._____

Activity	Steps and Action Taken

(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._____

Activity	Steps and Action Taken

(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._____

Activity	Steps and Action Taken

(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._____

Activity	Steps and Action Taken

(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._____

Activity	Steps and Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Activity 43: Use of Equipments (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._____

Activity	Steps and Action Taken

(Attach additional sheets if required)

Signature of the Academic Counselor/Supervisor

Appendix-1

Facilitywise distribution of Practical Experience

S.No	District Hospital		Community Health Centre		Primary Health Centre		Sub Health Centre		Urban Primary Health Centre	
	Days	Hrs	Days	Hrs	Days	Hrs	Days	Hrs	Days	Hrs
	22	**132**	**10**	**60**	**10**	**60**	**6**	**36**	**2**	**12**

Appendix-2

Monitoring Proforma for PSC Counsellors

Name of PSC …….

Name of the Student ……..

Sl. No	Name of the Skill	Skill training complete (Put only a tick marks)*				Signature With date
		District Hospital	CHC	PHC	Sub-Centre	
1)	Management of Common Communicable Diseases					
2)	Management of Common Non-Communicable Diseases					
3)	Management of Mental Illness					
4)	Dental Care					
5)	Geriatric Care					
6)	Eye Care and ENT					
7)	Common Conditions and Emergencies					
8)	Care in Pregnancy – Maternal Health					

*Put a tick mark in respective column for the skills completed in respective spells.

Appendix-2 (Contd….)

Monitoring Proforma for PSC Counselors

Name of PSC …….

Name of the Student ……..

Sl. No	Name of the Skill	Skill training complete (Put only a tick marks)*				Signature With date
		District Hospital	CHC	PHC	Sub-Centre	
9)	Neonatal and Infant Health (0 to 1 year of age)					
10)	Child Health, Adolescent Health					
11)	Reproductive Health and Contraceptive Services					
12)	Management of Common Illnesses					

*Put a tick mark in respective column for the skills completed in respective spells.

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

Appendix-4

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	Dates for submission of Examination form	November or December Examination

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.

Sl.No.	Course Title	Course Code	Intend to Take Examination (put** mark)
1.	Public Health and Primary Health Care Skills	BNSL043	

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……..

Appendix-5

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:

Course	**Item**	**Duration**	**Marks**
BNSL-043	1 Long case – Pregnant women/any case (NCD) History taking x 10 marks Physical examination x 10 marks Care and counseling x 5 marks	40 minutes	 10 10 5 25
	1 Short case Newborn/ child brief history and examination	20 minutes	20
	Counselling and Health Education (General) Common ailments fever, aches and pain etc.	10 minutes	25
	Viva (will be conducted by one internal and one external examiner)	30 minutes	30
	Total marks	**100 minutes**	**100**