WORKBOOK for TRAINING of MEDICAL OFFICERS in Pregnancy Care and Management of Common Obstetric Complications

Maternal Health Division
Ministry of Health & Family Welfare
Government of India

August 2009
WORKBOOK for TRAINING of MEDICAL OFFICERS in Pregnancy Care and Management of Common Obstetric Complications
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</table>
The Reproductive and Child Health Programme Phase-II, a flagship programme within National Rural Health Mission, aims to reduce maternal mortality ratio to less than 100 by 2010. There is a commitment from the Government of India and also from the States and UTs for providing Essential Obstetric Care at all facilities to achieve the goal of universal Skilled Birth Attendance. With this in view, Government of India has planned to operationalize all PHCs and FRUs in handling basic and comprehensive obstetric care, respectively.

Under the RCH Phase-II, the Government of India envisages that fifty percent of the PHCs and all the CHCs in all the districts would be made operational as 24-hour delivery centres, in a phased manner, by the year 2010. These centres would be responsible for providing Basic and Emergency Obstetric Care and Essential Newborn Care, including Newborn Resuscitation services round the clock. Almost all the States have laid emphasis in providing basic emergency obstetric care and skilled attendance at birth in the Project Implementation Plans (PIP) for RCH Phase-II.

As such, the Medical Officers, who are in-charge of these health facilities, would, therefore, have to be equipped enough to handle the common obstetric emergencies and provide the requisite care such as administration of parenteral oxytocics, antibiotics and anti-convulsant drugs, manual removal of the placenta, the conduction of assisted vaginal deliveries, etc.

Training tool for the training of Medical Officers at PHC on Pregnancy Care and Management of Common Obstetric Complications have been developed in accordance with the Guidelines for Pregnancy care and Management of Common Obstetric Complications by Medical Officers include and Trainers Guide, Handbook and Workbook for the Trainees to manage Essential Obstetric Care. These tools have been prepared by Maternal Health Division in collaboration with Jawaharlal Nehru Medical College, Belgaum with inputs from UNFPA and WHO. I hope the Workbook along with the Guideline’s & Handbook will facilitate Medical Officers from Primary Health Centres to build there skills in pregnancy care and management of common obstetric complications and help in ensuring the quality and uniformity in the trainings.

Date: 23.04.08

Shri Naresh Dayal,
Secretary H & FW.
New Delhi, India.
To achieve the goals for reduction of maternal mortality and morbidity, GoI has a commitment under Reproductive and Child Health Program to provide quality Antenatal, Postnatal and Intranatal care during pregnancy and child birth by a Skilled Birth Attendant. Timely identification and management of obstetric complications is the key to the survival of mothers.

To achieve this, Government of India envisages that fifty percent of the Primary Health Centres and all the Community Health Centres should be operationalised as 24-hour delivery centres with proficiency for providing basic and emergency obstetric services. These centres will also be responsible for providing pre-referral emergency care for women who develop complications during delivery. The training tools, i.e., Trainers’ Guide, Trainees’ Handbook and Workbook will help in imparting knowledge and skills to the MOs, which will help them in providing services to women in labour and obstetric emergencies thereby reducing maternal mortality.

The training package has been designed by the faculty of Jawaharlal Nehru Medical College, Belgaum particularly Dr. B.S. Kodkany, Dr. Kamal Patil, Dr. M.K. Swamy and Mr. Killeedar. Inputs have also been taken from professional bodies such as Federation of Obstetric and Gynaecological Societies of India (FOGSI), especially Dr. C.N. Purandere and Dr. Hema Diwakar, UN organizations, particularly Dr. Harish Kumar and Dr. Sonia Trikha of WHO-India and Dr. Dinesh Agarwal of UNFPA-India. I thank them all for their valuable contributions.

I also take this opportunity to acknowledge the contribution of all the experts, especially Dr. Deoki Nandan (Director, NIHFW), Dr. Kamala Ganesh (Ex H.O.D-Ob Gyn, MAMC, Delhi), Dr. (Mrs) N.S. Mahanshetti and faculty of all the Medical Colleges of Karnataka. I also acknowledge the support of WHO in organizing meetings, workshops and providing necessary inputs for accomplishing the preparation of the guidelines.

The sincere and hard work of Dr Narika Namshum, Dr. Himanshu Bhushan, Dr. Manisha Malhotra, Dr. Avani Pathak and Dr. Rajeev Aggarwal from Maternal Health Division, MoHFW needs special mention.

I hope the Handbook along with the Workbook & Guidelines will facilitate medical officers from primary health centres to build their skills in pregnancy care and management of common obstetric complications and help in ensuring high quality of trainings.

Date: 23.04.08

Aradhana Johri
Joint Secretary, MoHFW
New Delhi, India
NRHM has a commitment for reduction of maternal & infant mortality/morbidity so as to meet the National and International goals. The reduction of MMR is related to quality of services rendered and also handling of Basic and Comprehensive Obstetric Care services at the health facilities particularly at Primary and Secondary level of the facilities.

National Rural Health Mission has the goal of reducing the maternal mortality ratio to less than 100 per 100,000 live births by 2012 & infant mortality rate to less than 30 per 1000 live births. To achieve these objectives, steps have been taken under NRHM to appropriately strengthen all PHCs and FRUs in handling Basic and Comprehensive Obstetric Care including Care at Birth. However, for the improvement of service delivery, it is important that medical officers are re-oriented on care during pregnancy & childbirth so that facilities can become efficient in handling complications related to pregnancy & care of new born.

Gol has already launched the training of paramedical workers i.e., Nurses, ANMs & LHV for making them skilled in provision of care during pregnancy & child birth but the medical officers in rural primary care facilities have not been reoriented in these skills. These medical officers are also supposed to be the supervisors & trainers for the SBA training of Nurses, ANMs & LHV. Therefore the PHC MOs need to up-grade their skills & knowledge in order to manage & support their team in skill birth attendance.

To achieve this, Gol has developed training tools & guidelines for Medical Officers at primary health facilities. It includes Trainers Guide Handbook and Workbook for the Trainees to manage Essential Obstetric Care. These have been prepared by Maternal Health Division of this Ministry with inputs from experts, professionals, development partners & leaders in the field.

I hope these training tools will facilitate the trainers in orienting the medical officers from primary health facilities in proficient use of essential procedures described in training manual. Similarly, trainees will also be benefitted by the handbook and workbook which has been prepared in line with the Guidelines for Pregnancy care and Management of Common Obstetric Complications by Medical Officers”. I hope this will help in reducing the risk & trauma of pregnancy & child birth in community.

Date: 28.08.09

(Amit Mohan Prasad)
Joint Secretary H& FW
Government of India
With the launch of National Rural Health Mission, many positive changes have taken place in public health, infrastructure and service delivery but still there is a scope for improvement in the quality of services being rendered. Reduction of maternal and infant mortality is linked with the quality of care during pregnancy and child birth. Skilled attendance in every pregnancy and during birth is a proven strategy for ensuring quality of services and for reducing maternal mortality. Training of midwives and orientation of doctors is the key step which will help in providing skilled attendance during every pregnancy and birth taking place at public health facilities.

To improve skills of providers, training of ANMs/LHVs/SNs as Skilled Birth Attendant has already been in place but the Medical officers who are also the supervisors of this training need to be re-oriented on the skills. A guideline on Pregnancy Care and Management of Common Obstetric Complications for Medical officers working at PHC and CHC level was prepared for this purpose in the year 2005. However, states could not implement it because the training tools were not available. As such, with the help of the experts and development partners, we have now developed three books i.e. Trainers Guide, Trainees Handbook and Workbook as a training tool for the medical officers.

There was some delay in bringing these books to the final shape because certain technical strategies like Use of Oxytocin at all the health facilities and updated package of Essential New Born Care and Resuscitation etc. were being firmed up. A 10 days’ package for Medical officers is now in place but the guidelines are a facilitating tool. Objectives of the guidelines will only be achieved if there is a proper coordination, planning and decision making among all the key stakeholders within the state for conducting this training and utilizing the trained doctors at proper place.

I hope these training tools will facilitate both the trainers and trainees in reorientation of knowledge and skills for care during pregnancy and child birth and will help in reducing the risk & trauma of pregnancy & child birth in community. I take this opportunity to thank everyone who has contributed in framing the training package.

Date: 02.09.09

(Dr. Himanshu Bhushan)
Assistant Commissioner
Maternal Health Division
MOHFW
New-Delhi, INDIA
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<td>@</td>
<td>At the rate of</td>
</tr>
<tr>
<td>%</td>
<td>Per cent</td>
</tr>
<tr>
<td>AMTSRL</td>
<td>Active Management of Third Stage of Labour.</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante-natal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse-midwife</td>
</tr>
<tr>
<td>APH</td>
<td>Antepartum Haemorrhage</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>BPM</td>
<td>Beats Per Minute</td>
</tr>
<tr>
<td>c/o</td>
<td>Complaint of</td>
</tr>
<tr>
<td>CCT</td>
<td>Controlled Cord Traction</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CPD</td>
<td>Cephalopelvic Disproportion</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilation and Curettage</td>
</tr>
<tr>
<td>e.g.</td>
<td>For example</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>ENBC</td>
<td>Essential New Born Care</td>
</tr>
<tr>
<td>Etc.</td>
<td>Etcetra</td>
</tr>
<tr>
<td>FHR</td>
<td>Foetal Heart Rate</td>
</tr>
<tr>
<td>FHS</td>
<td>Foetal Heart Sound</td>
</tr>
<tr>
<td>FTD</td>
<td>Full Term Delivery</td>
</tr>
<tr>
<td>FOGSI</td>
<td>Federation of Obstetrics and Gynecological Societies of India</td>
</tr>
<tr>
<td>FRU</td>
<td>First Referral Unit</td>
</tr>
<tr>
<td>G(no.) P(no.) A(no.) L(no.)</td>
<td>Gravida (no.) Para (no.) Abortion (no.) Live Birth (no.)</td>
</tr>
<tr>
<td>GoI</td>
<td>Government of India</td>
</tr>
<tr>
<td>GPE</td>
<td>General Physical Examination</td>
</tr>
<tr>
<td>h/o</td>
<td>History of</td>
</tr>
<tr>
<td>Hb</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>Hg</td>
<td>Mercury</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HLD</td>
<td>High Level Disinfection</td>
</tr>
<tr>
<td>i.e.</td>
<td>That is</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron Folic Acid</td>
</tr>
<tr>
<td>I/o</td>
<td>Input/output</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>ICTC</td>
<td>Integrated Counselling and Testing Center</td>
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<tr>
<td>Inj.</td>
<td>Injection</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Death</td>
</tr>
<tr>
<td>IUGR</td>
<td>Intrauterine Growth Retardation</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>LLIN</td>
<td>Long Lasting Insecticide Treated Bednets</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
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<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>LR</td>
<td>Labour Room</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MOS</td>
<td>Medical Officers</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MRP</td>
<td>Manual Removal of Placenta</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>NBC</td>
<td>New Born Care</td>
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<tr>
<td>NIHFW</td>
<td>National Institute of Health and Family Welfare</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>NVBDCP</td>
<td>National Vector Borne Disease Control Programme</td>
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<td>NSAID</td>
<td>Non-steroidal Anti-inflammatory Drug</td>
</tr>
<tr>
<td>O/E</td>
<td>On Examination</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>OT</td>
<td>Operation Theater</td>
</tr>
<tr>
<td>P/A</td>
<td>Per Abdomen</td>
</tr>
<tr>
<td>P/S</td>
<td>Per Speculum</td>
</tr>
<tr>
<td>P/V</td>
<td>Per Vaginum</td>
</tr>
<tr>
<td>P(no.) L(no.) A(no.)</td>
<td>Pregnancy (no.) Live-birth (no.) Abortion (no.)</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PIH</td>
<td>Pregnancy Induced Hypertension</td>
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<td>PIP</td>
<td>Project Implementation Plan</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>PPH</td>
<td>Postpartum Haemorrhage</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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</tr>
<tr>
<td>PROM</td>
<td>Premature or Prelabour Rupture of Membranes</td>
</tr>
<tr>
<td>RL</td>
<td>Ringer Lactate</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RR</td>
<td>Respiratory Rate</td>
</tr>
<tr>
<td>RPR</td>
<td>Rapid Plasma Reagin</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
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<td>Tablet</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<td>UIP</td>
<td>Universal Immunization Programme</td>
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<tr>
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<td>Urinary Tract Infection</td>
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<tr>
<td>UNFPA</td>
<td>United Nation Population Fund Agency</td>
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<tr>
<td>VDRL</td>
<td>Venereal Disease Research Laboratory</td>
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<tr>
<td>vs</td>
<td>Versus</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ºC</td>
<td>Degree Centigrade</td>
</tr>
<tr>
<td>mg/mcg</td>
<td>Milligram/Microgram</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic Centimetre</td>
</tr>
<tr>
<td>cm</td>
<td>Centimetre</td>
</tr>
<tr>
<td>dl</td>
<td>Decilitre</td>
</tr>
<tr>
<td>gm</td>
<td>Gram</td>
</tr>
<tr>
<td>IU</td>
<td>International Units</td>
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<tr>
<td>kcal</td>
<td>Kilocalories</td>
</tr>
<tr>
<td>kg</td>
<td>Kilogram</td>
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<tr>
<td>L</td>
<td>Litre</td>
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<tr>
<td>Lb</td>
<td>Pound</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
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<tr>
<td>ml</td>
<td>Millilitre</td>
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<td>mm</td>
<td>Millimetre</td>
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<tr>
<td>U</td>
<td>Units</td>
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<tr>
<td>Name of the Medical Officer</td>
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<td>-----------------------------</td>
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<tr>
<td>Name of the Workplace</td>
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<td>Taluka and District</td>
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<td>Name of the Training Institute</td>
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<tr>
<td>Names of the Trainers</td>
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<tr>
<td>1.</td>
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<td>4.</td>
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<tr>
<td>Training Duration</td>
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<td>w.e.f. _____________________ to _____________________</td>
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<tr>
<td>Dates of Joining</td>
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<tr>
<td>Assessment (Tick any)</td>
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<tr>
<td>Satisfactory/Needs re-orientation</td>
<td></td>
</tr>
<tr>
<td>Name and Designation of Supervisor</td>
<td></td>
</tr>
<tr>
<td>Signature with date</td>
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**General Instructions to Trainees**

This workbook is a compulsory component of your training. You are required to maintain record of all your learning activities and other tasks that you perform during the course. These activities are to be performed under the supervision of the supervisor initially, whose remarks will guide you in improving your skills while practising independently.

The workbook would enable your trainers to have the first hand information about various tasks performed by you and help in assessing the practical hands-on experience gained by you. This would also be very useful to you for planning your activities in advance of the actual performance of the task. This record will also be given due weightage for your final assessment. You should keep this document with you whenever you are practising a skill, complete it and show it to your supervisor for his/her remarks and suggestions.

You are expected to keep the records in this workbook whenever you carry out any procedure under the supervision of the designated supervisor. You may add more items after discussion with your supervisor, whenever required. You must show the record to your supervisor after he/she has observed the procedure and request him/her to give the remarks and suggestions regarding where you need to improve your competencies. Please be honest in completing this workbook, since this is meant to help you acquire competencies. It is very important that you know your weak areas and improve upon them during the training period.

We have also given case studies in your handbook to stimulate your analytic and decision-making skills in relation to selected essential and emergency obstetric care and newborn care which you are likely to face in the field settings. Please go through these and also discuss these with your supervisors. Please keep the workbook even after you finish your training. This would be handy in your practice later on.

**Wish you the best of luck**
## TRAINING SESSION

<table>
<thead>
<tr>
<th>Day</th>
<th>Session</th>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1a</td>
<td>Registration, Welcome and Introduction to problems of Maternal Health – Maternal Mortality and objectives of Medical Officers Training, Pre-test questionnaire, Orientation to the services and facilities available in hospital</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td>1b</td>
<td>Care during pregnancy – Antenatal Care</td>
<td>1 hour</td>
</tr>
<tr>
<td>2</td>
<td>2a</td>
<td>Intrapartum care and partograph</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td>2b</td>
<td>Active Management of Third Stage of Labour (AMTSL)</td>
<td>1 hour</td>
</tr>
<tr>
<td>3</td>
<td>3a</td>
<td>Instrumental delivery</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td>3b</td>
<td>Postpartum hemorrhage and shock</td>
<td>1 hour</td>
</tr>
</tbody>
</table>
| 4   | 4       | Essential newborn care  
a) Care of baby at the time of birth  
b) Care of New Born in post natal ward | 2 hours |
| 5   | 5a      | Hypertension in pregnancy | 1 hour |
|     | 5b      | Eclampsia | 1 hour |
| 6   | 6a      | Postpartum care | 1 hour |
|     | 6b      | Puerperal sepsis | 1 hour |
| 7   | 7a      | Anemia | 1 hour |
|     | 7b      | Other problems during pregnancy  
• Urinary tract infection  
• Hyperemesis gravidum  
• Retention of urine  
• Premature or prelabour rupture of membranes | 1 hour |
| 8   | 8a      | Abortion | 1 hour |
|     | 8b      | Antepartum hemorrhage | 1 hour |
| 9   | 9a      | Other problems during labour and delivery  
• Prolonged and obstructed labour and partograph  
• Preterm labour  
• Foetal distress  
• Prolapsed cord  
• Twins | 2 hours |
|     | 9b      | Other problems during postpartum period  
• Inversion of uterus  
• Problems with breast feeding | 1 hour |
| 10  | 10a     | Prevention of infection | 1 hour |
|     | 10b     | Revision of 9 days’ sessions  
Post-test questionnaire and feedback from trainees | 2 hours |

- Monitoring and assessment will be on a daily basis
- Final certification will be done on the last day of training
Recommended Client Practice by Trainee

<table>
<thead>
<tr>
<th>Activity</th>
<th>Observe</th>
<th>Perform Independently</th>
</tr>
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<tbody>
<tr>
<td>1. Antenatal check-up</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>2. Identification and Management of different complications of pregnancy</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Preparing delivery trolley/equipment</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>4. Perform PV examination</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>5. Monitor labour, plot and interpret partograph</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6. a) Conduct normal delivery</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>b) Active Management of 3rd stage of labour</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>c) Examination of placenta, membranes, Umbilical Cord</td>
<td>2</td>
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</tr>
<tr>
<td>7. ENBC procedures and assess and provide NBC including resuscitation of *new born and check weight.</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>8. Assist the mother to initiate and continue BF</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>9. Management of PPH*</td>
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</tr>
<tr>
<td>10. Removal of products of conception/clots under supervision*</td>
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</tr>
<tr>
<td>11. Identification and Management of perineal tears</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12. Emergency management of eclampsia*</td>
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</tr>
<tr>
<td>13. Identification and Management of other complications of labour</td>
<td>3</td>
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<tr>
<td>14. Postnatal checkup</td>
<td>2</td>
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<tr>
<td>15. Identification and Management of complications of post partum period</td>
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<tr>
<td>16. Identification and Management of danger signs in neonate</td>
<td>2</td>
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</tr>
<tr>
<td>17. Emergency obstetric procedure</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Forceps delivery/Vacuum extraction*</td>
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</tbody>
</table>

- The trainers will ensure practising of these skills by trainees and monitor quality.
- Trainee should keep a daily signed Cumulative Client Practice Record.
- This record will be utilized by Trainer for certification.

* Note: In case there is no client/patient available on whom any of the above skills can be performed, the trainer should use models and innovative approaches to enable the trainees perform the requisite skills.
# Record/Assessment Form for the Trainee

**Recommended Client Practice by Trainee**

<table>
<thead>
<tr>
<th></th>
<th>Activity</th>
<th>Observe</th>
<th>Perform Independently</th>
<th>Grading by Trainer</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Antenatal check-up</td>
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</tr>
<tr>
<td>2</td>
<td>Identification and Management of different complications of pregnancy</td>
<td></td>
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<tr>
<td>3</td>
<td>Preparing delivery trolley/equipment</td>
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</tr>
<tr>
<td>4</td>
<td>Perform PV examination</td>
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</tr>
<tr>
<td>5</td>
<td>Monitor labour, plot and interpret partograph</td>
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</tr>
<tr>
<td>6</td>
<td>a) Conduct normal delivery</td>
<td></td>
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<tr>
<td></td>
<td>b) Active Management of 3&lt;sup&gt;rd&lt;/sup&gt; stage of labour</td>
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<tr>
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Remarks: _______________________________________________________

Grading: **Satisfactory/Needs re-orientation**

Name and Signature: _____________________________________________

Date: _______________

Note: In the 'Trainers' guide there is same form for filling and keeping record by the trainer.
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History : G P A L

<table>
<thead>
<tr>
<th>Order of delivery</th>
<th>Mode of delivery</th>
<th>Complication</th>
<th>Outcome of the pregnancy</th>
</tr>
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Contraceptive History :

Past History :

Family History :

2.1.1
## CASE SHEET: ANTENATAL CARE

### GPE
- **Weight**
- **Pulse**
- **Blood Pressure**
- **RR**
- **Temperature**
- **Pallor**
- **Oedema**
- **Jaundice**
- **Breasts**
- **Nipples: Normal/Inverted**

### Systemic Examination
- **CVS**
- **RS**
  - **Per Abdomen:** Fundal Height
  - **Lie**
  - **Presentation**
  - **FHS**
  - **Previous Scar/any other observation**

### Vaginal Examination (if necessary)
- **Provisional Diagnosis:**
- **Investigations:** Hb
- (**Optional**) Blood Group & Rh typing
- Urine Routine Examination:
  - **RPR/VDRL**
  - **HIV**
  - **HBsAg**
  - **USG**

### Prophylaxis
- **Tab I FA**
- **Inj. TT**
- 1st Dose 2nd Dose

### Any other treatment given

### Counselling

### Assessment Grading (Satisfactory/Unsatisfactory)

### Name and Signature of Trainer/Supervisor:
## ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History :

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Contraceptive History :

Past History :

Family History :

2.2.1
CASE SHEET: ANTENATAL CARE

GPE
Weight
Pulse
Blood Pressure
RR
Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
CVS
RS

Per Abdomen : Fundal Height
Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)
Provisional Diagnosis :

Investigations :
Hb
Blood Group & Rh typing
Urine Routine Examination:
RPR/VDRL*
HIV*
HBsAg*
USG*

Prophylaxis :
Tab I FA
Inj. TT 1st Dose 2nd Dose

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No: 
Age : Date of Examination: 
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History :

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Contraceptive History :

Past History :

Family History :

02_F18J_08092015_REGISTER_001.jpg
GPE

Weight
Pulse
Blood Pressure
RR
Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination

CVS
RS

Per Abdomen:

Fundal Height
Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:

Hb
Blood Group & Rh typing
Urine Routine Examination:
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Prophylaxis:

Tab I FA
Inj. TT 1st Dose 2nd Dose

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea :
months days

Any complaints :

Menstrual History :
Regular/Irregular Cycles
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Obstetric History :
G P A L

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Contraceptive History :

Past History :

Family History :

2.4.1
CASE SHEET: ANTENATAL CARE

GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
- Per Abdomen: Fundal Height
- Lie
- Presentation
- FHS
- Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:
- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
  - RPR/VDRL*
  - HIV*
  - HBsAg*
  - USG*

Prophylaxis:
- Tab I FA
- Inj. TT 1st Dose □ 2nd Dose □

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History : 
CASE SHEET: ANTENATAL CARE

GPE
Weight
Pulse
Blood Pressure
RR
Temperature
Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
CVS
RS
Per Abdomen : Fundal Height
  Lie
  Presentation
  FHS
  Previous Scar/any other observation

Vaginal Examination (if necessary)
Provisional Diagnosis :
Investigations :
(*Optional)
  Blood Group & Rh typing
  Urine Routine Examination:
    RPR/VDRL*
    HIV*
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    USG*

Prophylaxis : Tab I FA
  Inj. TT  1st Dose ☐  2nd Dose ☐
Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
# ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History :

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Contraceptive History :

Past History :

Family History :

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2.6.1
GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS

Per Abdomen: Fundal Height, Lie, Presentation, FHS, Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:
- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
- RPR/VDRL*
- HIV*
- HBsAg*
- USG*

Prophylaxis:
- Tab IFA
- Inj. TT 1st Dose □ 2nd Dose □

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :

2.7.1
CASE SHEET: ANTENATAL CARE

GPE

Weight
Pulse
Blood Pressure
RR
Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination

CVS

RS

Per Abdomen : Fundal Height
Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations :

Hb
Blood Group & Rh typing
Urine Routine Examination:
RPR/VDRL*
HIV*
HBsAg*
USG*

Prophylaxis :

Tab I F A
Inj. TT 1st Dose □ 2nd Dose □

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

2.7.2
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :
CASE SHEET: ANTENATAL CARE

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Urine Routine Examination:
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Prophylaxis:
Tab I FA
Inj. TT
1st Dose
2nd Dose

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History :
- Regular/Irregular Cycles
- LMP
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Obstetric History :
- G P A L

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Contraceptive History :

Past History :

Family History :

2.9.1
GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature
  - Pallor
  - Oedema
  - Jaundice
  - Breasts
  - Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
  - Per Abdomen: Fundal Height, Lie, Presentation, FHS, Previous Scar/any other observation

Vaginal Examination (if necessary)
- Provisional Diagnosis:
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    - USG*

- Prophylaxis: Tab I F A
- Any other treatment given:

- Counselling:

**Assessment Grading (Satisfactory/Unsatisfactory)**

Name and Signature of Trainer/Supervisor:
**ANTENATAL CASE RECORD**

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

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EDD

Obstetric History :

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Contraceptive History :

Past History :

Family History :
Case Sheet: Antenatal Care

GPE
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Blood Pressure
RR
Temperature

Systemic Examination
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RS
Per Abdomen
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Presentation
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Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis

Investigations
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Blood Group & Rh typing
RPR/VDRL*
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HBsAg*
USG*

Prophylaxis
Tab I F A
Inj. TT 1st Dose 2nd Dose

Any other treatment given

Counselling

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
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<table>
<thead>
<tr>
<th>Obstetric History</th>
<th>G P A L</th>
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| Contraceptive History | |
|-----------------------||

| Past History | |
|--------------||

| Family History | |
|----------------||

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2.11.1
GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
- Per Abdomen: Fundal Height, Lie, Presentation
- FHS
- Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:
- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
  - RPR/VDRL*
  - HIV*
  - HBsAg*
  - USG*

Prophylaxis:
- Tab I FA
- Inj. TT 1st Dose □ 2nd Dose □

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :
Case Sheet: Antenatal Care

GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature
  - Pallor
  - Oedema
  - Jaundice
  - Breasts
  - Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
  - Per Abdomen: Fundal Height
  - Lie
  - Presentation
  - FHS
  - Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations: Hb
(*) Optional
- Blood Group & Rh typing
- Urine Routine Examination:
  - RPR/VDRL*
  - HIV*
  - HBsAg*
  - USG*

Prophylaxis:
- Tab I FA
- Inj. TT 1st Dose 2nd Dose

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : 
Registration No: 

Age : 
Date of Examination: 

Address : 

History of Amenorrhoea : months days

Any complaints : 

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

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Contraceptive History : 

Past History : 

Family History : 

2.13.1
Case Sheet: Antenatal Care

GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
- Per Abdomen: Fundal Height, Lie, Presentation, FHS, Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:
- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
  - RPR/VDRL*
  - HIV*
  - HBsAg*
  - USG*

Prophylaxis:
- Tab I F A
- Inj. TT 1st Dose □ 2nd Dose □

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

2.13.2
# ANTENATAL CASE RECORD

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**History of Amenorrhoea**: months days

**Any complaints**: 

**Menstrual History**: Regular/Irregular Cycles

LMP

EDD

**Obstetric History**: G P A L

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**Contraceptive History**: 

**Past History**: 

**Family History**: 

2.14.1
# CASE SHEET: ANTENATAL CARE

## GPE

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<tbody>
<tr>
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<tr>
<td>Pulse</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
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<tr>
<td>RR</td>
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<tr>
<td>Temperature</td>
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</tr>
<tr>
<td>Pallor</td>
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</tr>
<tr>
<td>Oedema</td>
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<tr>
<td>Jaundice</td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
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<td>Nipples: Normal/Inverted</td>
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## Systemic Examination

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
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<tbody>
<tr>
<td>CVS</td>
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<tr>
<td>RS</td>
<td></td>
</tr>
<tr>
<td>Per Abdomen</td>
<td>Fundal Height</td>
</tr>
<tr>
<td></td>
<td>Lie</td>
</tr>
<tr>
<td></td>
<td>Presentation</td>
</tr>
<tr>
<td></td>
<td>FHS</td>
</tr>
<tr>
<td></td>
<td>Previous Scar/any other observation</td>
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## Vaginal Examination (if necessary)

### Provisional Diagnosis

<table>
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<tr>
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<th>Hb</th>
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### Investigations

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### Prophylaxis

<table>
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<tr>
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### Any other treatment given

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### Counselling

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## Assessment Grading (Satisfactory/Unsatisfactory)

|                   |             |

Name and Signature of Trainer/Supervisor:

---

2.14.2
ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History :

<table>
<thead>
<tr>
<th>Order of delivery</th>
<th>Mode of delivery</th>
<th>Complication</th>
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Contraceptive History :

Past History :

Family History :
CASE SHEET: ANTENATAL CARE

GPE
Weight
Pulse
Blood Pressure
RR
Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
CVS
RS
Per Abdomen : Fundal Height
Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)
Provisional Diagnosis :

Investigations :
Hb
Blood Group & Rh typing
Urine Routine Examination:
RPR/VDRL*
HIV*
HBsAg*
USG*

Prophylaxis :
Tab I F A
Inj. TT 1st Dose 2nd Dose

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/ Irregular Cycles

LMP

EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :

2.16.1
GPE
Weight
Pulse
Blood Pressure
RR
Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
CVS
RS

Per Abdomen : Fundal Height

Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations :
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Blood Group & Rh typing
Urine Routine Examination:
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HIV*
HBsAg*
USG*

Prophylaxis :
Tab I F A
Inj. TT 1st Dose  2nd Dose

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No: 
Age : Date of Examination: 
Address : 

History of Amenorrhoea : months days 
Any complaints : 

Menstrual History : Regular/Irregular Cycles 
LMP 
EDD 

Obstetric History : G P A L 

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Contraceptive History : 

Past History : 

Family History :
## Case Sheet: Antenatal Care

### GPE

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- Pallor
- Oedema
- Jaundice
- Breasts
- Nipples: Normal/Inverted

### Systemic Examination

- CVS
- RS
  - Per Abdomen: Fundal Height
  - Lie
  - Presentation
  - FHS
  - Previous Scar/any other observation

### Vaginal Examination (if necessary)

- Provisional Diagnosis:

### Investigations

- (*Optional)

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### Prophylaxis

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<td>Inj. TT</td>
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### Any other treatment given

- 

### Counselling

- 

### Assessment Grading (Satisfactory/Unsatisfactory)

### Name and Signature of Trainer/Supervisor:

- 

2.17.2
### ANTENATAL CASE RECORD

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**History of Amenorrhoea**: months days

**Any complaints**: 

**Menstrual History**: Regular/Irrregular Cycles
  - LMP
  - EDD

**Obstetric History**: G P A L

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**Contraceptive History**: 

**Past History**: 

**Family History**: 

2.18.1
GPE
- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination
- CVS
- RS
- Per Abdomen: Fundal Height
- Lie
- Presentation
- FHS
- Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations: Hb
(*Optional)
- Blood Group & Rh typing
- Urine Routine Examination:
- RPR/VDRL*
- HIV*
- HBsAg*
- USG*

Prophylaxis: Tab I FA

Inj. TT 1st Dose  2nd Dose

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
ANTENATAL CASE RECORD

Name : Registration No:
Age : Date of Examination:
Address :

History of Amenorrhoea : months days
Any complaints :

Menstrual History : Regular/Irregular Cycles
LMP
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Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :
CASE SHEET: ANTENATAL CARE

GPE
Weight
Pulse
Blood Pressure
RR
Temperature

Systemic Examination
CVS
RS
Per Abdomen :
Fundal Height
Lie
Presentation
FHS
Previous Scar/any other observation

Vaginal Examination (if necessary)
Provisional Diagnosis :

Investigations :
Hb
Blood Group & Rh typing
Urine Routine Examination:
RPR/VDRL*
HIV*
HBsAg*
USG*

Prophylaxis :
Tab I FA
Inj. TT 1st Dose 2nd Dose

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

2.19.2
ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

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Contraceptive History :

Past History :

Family History :

2.20.1
CASE SHEET: ANTENATAL CARE

GPE

- Weight
- Pulse
- Blood Pressure
- RR
- Temperature

Pallor
Oedema
Jaundice
Breasts
Nipples: Normal/Inverted

Systemic Examination

- CVS
- RS

- Per Abdomen: Fundal Height
- Lie
- Presentation
- FHS
- Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis:

Investigations:

- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
- RPR/VDRL*
- HIV*
- HBsAg*
- USG*

Prophylaxis:

- Tab I F A
- Inj. TT 1" Dose 2nd Dose

Any other treatment given:

Counselling:

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

2.20.2
INTRAPARTUM RECORD

Name: 
Age: 
Registration No.: 

Date of Admission: 
Address: 
Registered/Unregistered: 

Complaints: Amenorrhea months days

Pain Abdomen since: 
Bleeding P/V: 
Watery discharge P/V: 
Any other complaints: 

Menstrual History: Regular/Irregular Cycles
LMP: 
EDD: 

Obstetric History: G P A L

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<th>Mode of delivery-normal/instrumental/LSCS</th>
<th>Complication if any</th>
<th>Outcome of the pregnancy-live birth/stillbirth</th>
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Past Medical History: 

Family History: 

GPE

Pulse 
Pallor
Blood Pressure 
Oedema
RR 
Icterus
Temp 

Systemic Examination:

CVS
RS

Per Abdomen: Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination: Cervical effacement
Cervical dilation
Status of membranes Absent □ Present □
Station of presenting part:
Colour of liquor

Pelvic Assessment: Adequate/not adequate
Diagnosis:
Investigations: Hb
Urine
Blood Group & Rh
Any other
In Latent Phase:

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Pulse</th>
<th>BP</th>
<th>Contraction</th>
<th>FHS</th>
<th>PV</th>
<th>Advice</th>
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</table>

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

A) Foetal Condition

<table>
<thead>
<tr>
<th>Foetal heart rate</th>
<th>200</th>
<th>190</th>
<th>180</th>
<th>170</th>
<th>160</th>
<th>150</th>
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<th>110</th>
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<th>90</th>
<th>80</th>
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</table>

Amniotic fluid

B) Labour

<table>
<thead>
<tr>
<th>Cervix (cm) [Plot X]</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
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<table>
<thead>
<tr>
<th>Hours Time</th>
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<tbody>
<tr>
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Alert

Action

C) Interventions

<table>
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<th>Drugs and IV fluids given</th>
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D) Maternal Condition

<table>
<thead>
<tr>
<th>Pulse and BP</th>
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<tbody>
<tr>
<td>180</td>
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<table>
<thead>
<tr>
<th>Temp (°C)</th>
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<tbody>
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</table>

*Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for	: (if applicable)

Date and time of delivery	:

Delivery Notes

Mother	:	Mode of delivery: Normal □ Assisted □ LSCS □
Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL	:
○ IM Oxytocin 10 U
○ CCT
○ Uterine Massage

Pulse
BP
Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes	:	Complete/Incomplete

Baby	:	Sex	M □ F □
Cried immediately/Resuscitation needed
Colour: Pink/Blue/Pale
Tone: Normal/Flaccid
Weight:

Urine	:	Passed/not passed
Meconium	:	Passed/not passed
Congenital anomalies	:	Yes/No
If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
Date:
INTRAPARTUM RECORD

Name:  
Age:  
Registration No.:  

Date of Admission:  
Address:  
Registered/Unregistered:  

Complaints:  Amenorrhea  months  days  
Pain Abdomen since:  
Bleeding P/V:  
Watery discharge P/V:  
Any other complaints:  

Menstrual History:  Regular/Irregular Cycles  
LMP:  
EDD:  

Obstetric History:  G  P  A  L  

<table>
<thead>
<tr>
<th>Order of delivery</th>
<th>Mode of delivery-normal/instrumental/LCS</th>
<th>Complication if any</th>
<th>Outcome of the pregnancy-live birth/stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3</td>
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</tbody>
</table>

Past Medical History:  

Family History:  

GPE  

Pulse  
Blood Pressure  
RR  
Temp  
Pallor  
Oedema  
Icterus
Systemic Examination:

CVS

RS

Per Abdomen : Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination : Cervical effacement
Cervical dilation
Status of membranes Absent □ Present □
Station of presenting part:

Colour of liquor

Pelvic Assessment : Adequate/not adequate

Diagnosis :

Investigations :
Hb
Urine
Blood Group & Rh
Any other
In Latent Phase:

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Pulse</th>
<th>BP</th>
<th>Contraction</th>
<th>FHS</th>
<th>PV</th>
<th>Advice</th>
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

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<tr>
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<thead>
<tr>
<th>Amniotic fluid</th>
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<thead>
<tr>
<th>B) Labour</th>
<th>Date &amp; Time of ROM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix (cm)</td>
<td></td>
</tr>
<tr>
<td>[Plot X]</td>
<td></td>
</tr>
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<td>10</td>
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<td>9</td>
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<td>4</td>
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</tr>
<tr>
<td>Hours Time</td>
<td></td>
</tr>
<tr>
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<td></td>
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</tbody>
</table>

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

| Contraction per 10 min |                           |
| 1                     |                           |
| 2                     |                           |
| 3                     |                           |
| 4                     |                           |
| 5                     |                           |

| C) Interventions      |                           |
| Drugs and IV fluids   |                           |
| given                |                           |

<table>
<thead>
<tr>
<th>D) Maternal Condition</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Pulse and BP</td>
<td></td>
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<tr>
<td>70</td>
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<tr>
<td>60</td>
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</table>

| Temp (°C)             |                           |

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for: (if applicable)

Date and time of delivery:

Delivery Notes

Mother:
Mode of delivery: Normal □ Assisted □ LSCS □
Indication in case of Instrumental delivery/LSCS
Date & Time of delivery

AMTS:
- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse
BP

Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes:
Complete/Incomplete

Baby:
Sex: M □ F □
Cried immediately/Resuscitation needed
Colour: Pink/Blue/Pale
Tone: Normal/Flaccid
Weight:
Urine: Passed/not passed
Meconium: Passed/not passed
Congenital anomalies: Yes/No
If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
Date:
**INTRAPARTUM RECORD**

Name:  
Age:  
Registration No.  

Date of Admission:  
Address:  
Registered/Unregistered:  

Complaints: Amenorrhea months days 
Pain Abdomen since:  
Bleeding P/V:  
Watery discharge P/V:  
Any other complaints:  

Menstrual History: Regular/Irregular Cycles  
LMP:  
EDD:  

Obstetric History:  
G P A L  

<table>
<thead>
<tr>
<th>Order of delivery</th>
<th>Mode of delivery-normal/instrumental/LSCS</th>
<th>Complication if any</th>
<th>Outcome of the pregnancy-live birth/stillbirth</th>
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</thead>
<tbody>
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</tbody>
</table>

Past Medical History:  
Family History:  
GPE  

<table>
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<tr>
<th>Pulse</th>
<th>Pallor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Oedema</td>
</tr>
<tr>
<td>RR</td>
<td>Icterus</td>
</tr>
<tr>
<td>Temp</td>
<td></td>
</tr>
</tbody>
</table>
Systemic Examination:

CVS

RS

Per Abdomen :

- Fundal Height
- Presentation
- Uterine Contractions
- FHS
- Any other observation

Vaginal Examination :

- Cervical effacement
- Cervical dilation
- Status of membranes
  - Absent □
  - Present □
- Station of presenting part:
  - Colour of liquor

Pelvic Assessment :

- Adequate/not adequate

Diagnosis :

Investigations :

- Hb
- Urine
- Blood Group & Rh
- Any other
In Latent Phase:

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Pulse</th>
<th>BP</th>
<th>Constructions</th>
<th>FHS</th>
<th>PV</th>
<th>Advice</th>
</tr>
</thead>
</table>

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

Name:     W/o:  age:  parity:  reg. no:

Date & Time of Admission    Date & Time of ROM:

A) Foetal Condition

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Amniotic fluid

B) Labour

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<th>Cervix (cm) [Plot X]</th>
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<th>3</th>
<th>2</th>
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<th>Hours</th>
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<th>4</th>
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<th>7</th>
<th>8</th>
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<th>10</th>
<th>11</th>
<th>12</th>
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<table>
<thead>
<tr>
<th>Contractions per 10 min</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</table>

C) Interventions

<table>
<thead>
<tr>
<th>Drugs and IV fluids given</th>
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D) Maternal Condition

<table>
<thead>
<tr>
<th>Pulse and BP</th>
<th>180</th>
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</tr>
</thead>
</table>

| Temp (°C) |   |   |   |   |   |   |   |   |   |   |   |
|-----------|---|---|---|---|---|---|---|---|---|---|---|---|---|

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for (if applicable)

Date and time of delivery:

Delivery Notes

Mother:

Mode of delivery: Normal [ ] Assisted [ ] LSCS [ ]
Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL:

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse
BP
Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes:

Complete/Incomplete

Baby:

Sex M [ ] F [ ]
Cried immediately/Resuscitation needed
Colour: Pink/Blue/Pale
Tone: Normal/Flaccid
Weight:

Urine: Passed/not passed
Meconium: Passed/not passed
Congenital anomalies: Yes/No
If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
## INTRAPARTUM RECORD

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<th>Name:</th>
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<td>Registered/Unregistered :</td>
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<td>Complaints :</td>
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<td>Pain Abdomen since:</td>
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<tr>
<td>Bleeding P/V :</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watery discharge P/V :</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other complaints :</td>
<td></td>
<td></td>
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<tr>
<td>Menstrual History :</td>
<td>Regular/Irregular Cycles</td>
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</tr>
<tr>
<td>LMP:</td>
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<td></td>
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<tr>
<td>EDD:</td>
<td></td>
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<tr>
<td>Obstetric History :</td>
<td>G P A L</td>
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Past Medical History:

Family History:

GPE

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<tr>
<td>Temp</td>
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3.4.1
Systemic Examination:

CVS
RS

Per Abdomen : Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination : Cervical effacement
Cervical dilation
Status of membranes Absent □ Present □
Station of presenting part:
Colour of liquor

Pelvic Assessment : Adequate/not adequate
Diagnosis :
Investigations : Hb
Urine
Blood Group & Rh
Any other
In Latent Phase:

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Pulse</th>
<th>BP</th>
<th>Contractions</th>
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<th>Advice</th>
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
CASE SHEET: INTRAPARTUM RECORD

PARTOGRAPH

Name:     W/o:  Age:  Parity:  Reg. No:

Date & Time of Admission     Date & Time of ROM:

A) Foetal Condition

Foetal heart rate
200
190
180
170
160
150
140
130
120
110
100
90
80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]
10
9
8
7
6
5
4

Hours Time
1 2 3 4 5 6 7 8 9 10 11 12

Contractions per 10 min
5
4
3
2
1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP
180
170
160
150
140
130
120
110
100
90
80
70
60

Temp (°C)

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for (if applicable):

Date and time of delivery:

Delivery Notes

Mother:

Mode of delivery: Normal □ Assisted □ LSCS □

Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL:

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes:

Complete/Incomplete

Baby:

Sex M □ F □

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine: Passed/not passed

Meconium: Passed/not passed

Congenital anomalies: Yes/No

If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
INTRAPARTUM RECORD

Name: 
Age: 
Registration No.

Date of Admission:
Address:
Registered/Unregistered:
Complaints: Amenorrhea, months, days
Pain Abdomen since:
Bleeding P/V:
Watery discharge P/V:
Any other complaints:

Menstrual History: Regular/Irregular Cycles
LMP: 
EDD:

Obstetric History: G P A L

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Past Medical History:

Family History:

GPE

Pulse: Pallor
Blood Pressure: Oedema
RR: Icterus
Temp:
Systemic Examination:

CVS
RS

Per Abdomen : Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination : Cervical effacement
Cervical dilation
Status of membranes  Absent  Present
Station of presenting part:
Colour of liquor

Pelvic Assessment : Adequate/not adequate

Diagnosis :

Investigations : Hb
Urine
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Any other
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

Name:     W/o:  Age:  Parity:  Reg. No:

Date & Time of Admission

Date & Time of ROM:

A) Foetal Condition
   
   Foetal heart rate
   
   200
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   Amniotic fluid

B) Labour
   
   Cervix (cm) [Plot X]
   
   10
   9
   8
   7
   6
   5
   4
   3
   2
   1

   Hours
   
   Time
   
   1
   2
   3
   4
   5
   6
   7
   8
   9
   10
   11
   12

   Alert
   
   Action

   Contractions per 10 min
   
   5
   4
   3
   2
   1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition
   
   Pulse and BP
   
   180
   170
   160
   150
   140
   130
   120
   110
   100
   90
   80
   70
   60

   Temp (°C)

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for (if applicable):

Date and time of delivery:

Delivery Notes

Mother:
- Mode of delivery: Normal [ ] Assisted [ ] LSCS [ ]
- Indication in case of Instrumental delivery/LSCS
- Date & Time of delivery

AMTSL:
- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse
BP
Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes:
- Complete/Incomplete

Baby:
- Sex: M [ ] F [ ]
- Cried immediately/Resuscitation needed
- Colour: Pink/Blue/Pale
- Tone: Normal/Flaccid
- Weight:
- Urine: Passed/not passed
- Meconium: Passed/not passed
- Congenital: Yes/No
  If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
**INTRAPARTUM RECORD**

Name: ___________________________  Age: _______  Registration No. _______

Date of Admission: _______________________

Address: ____________________________

Registered/Unregistered: __________________

Complaints: Amenorrhea  months  days

Pain Abdomen since: ______________________

Bleeding P/V: ___________________________

Watery discharge P/V: _____________________

Any other complaints: ____________________

Menstrual History: Regular/ Irregular Cycles

LMP: ___________________

EDD: ___________________

Obstetric History: G  P  A  L

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Past Medical History:

Family History:

GPE

- Pulse
- Blood Pressure
- RR
- Temp

- Pallor
- Oedema
- Icterus
CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS
RS

Per Abdomen :
Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination :
Cervical effacement
Cervical dilation
Status of membranes Absent  Present
Station of presenting part:
Colour of liquor

Pelvic Assessment :
Adequate/not adequate

Diagnosis :

Investigations :
Hb
Urine
Blood Group & Rh
Any other
In Latent Phase:

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<th>PV</th>
<th>Advice</th>
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
### PARTOGRAPH

**Name:**

**W/o:**

**Age:**

**Parity:**

**Reg. No.:**

#### Date & Time of Admission

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#### PartoGraph

**A) Foetal Condition**

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**Amniotic fluid**

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**B) Labour**

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<th>Time</th>
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**Alert Action**

**Contraction per 10 min**

| 5 | 4 | 3 | 2 | 1 |

**C) Interventions**

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**D) Maternal Condition**

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Needs referral to FRU for : (if applicable)

Date and time of delivery :

Delivery Notes

Mother :

Mode of delivery: Normal ☐ Assisted ☐ LSCS ☐

Indication in case of Instrumental delivery/LCS

Date & Time of delivery

AMTSAL :

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes :

Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

Meconium : Passed/not passed

Congenital anomalies : Yes/No

If Yes, specify

Assessment Grading (Satisfactory/ Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
### INTRAPARTUM RECORD

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<td>Pain Abdomen since:</td>
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**Menstrual History**: Regular/Irregular Cycles  
LMP:  
EDD:  

**Obstetric History**: G P A L  

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**Past Medical History:**

**Family History:**

**GPE**

- Pulse  
- Blood Pressure  
- RR  
- Temp  

Pallor  
Oedema  
Icterus
Systemic Examination:

CVS
RS

Per Abdomen : Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination : Cervical effacement
Cervical dilation
Status of membranes  Absent  Present
Station of presenting part:

Colour of liquor

Pelvic Assessment : Adequate/not adequate
Diagnosis :
Investigations : Hb
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

A) Foetal Condition

Foetal heart rate

200 190 180 170 160 150 140 130 120 110 100 90 80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

Alert Action

Hours Time

1 2 3 4 5 6 7 8 9 10 11 12

Contraction per 10 min

1 2 3 4 5

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP

180 170 160 150 140 130 120 110 100 90 80 70 60

Temp (°C)

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
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Date and time of delivery:

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Mother: Mode of delivery: Normal □ Assisted □ LSCS □ Indication in case of Instrumental delivery/LSCS Date & Time of delivery

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- CCT
- Uterine Massage

Pulse
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Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes: Complete/Incomplete

Baby: Sex M □ F □
Cried immediately/Resuscitation needed
Colour: Pink/Blue/Pale
Tone: Normal/Flaccid
Weight:
Urine: Passed/not passed
Meconium: Passed/not passed
Congenital anomalies: Yes/No
If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
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<td>Regular/Irregular Cycles</td>
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<tr>
<td>Obstetric History:</td>
<td>G P A L</td>
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Past Medical History: 

Family History: 

GPE

| Pulse | Pallor | Blood Pressure | Oedema | RR | Icterus | Temp |
### Systemic Examination:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
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<tbody>
<tr>
<td>CVS</td>
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<td>RS</td>
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<td>Per Abdomen</td>
<td>Fundal Height</td>
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<td></td>
<td>Presentation</td>
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<td></td>
<td>Uterine Contractions</td>
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<td>FHS</td>
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<td>Any other observation</td>
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### Vaginal Examination:

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<th>Parameter</th>
<th>Value</th>
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<td>Cervical effacement</td>
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<td>Cervical dilation</td>
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<td>Status of membranes: Absent [ ] Present [ ]</td>
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<td>Station of presenting part:</td>
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<td>Colour of liquor</td>
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### Pelvic Assessment:

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<td>Pelvic Assessment</td>
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### Diagnosis:

#### Investigations:

- Hb
- Urine
- Blood Group & Rh
- Any other
In Latent Phase:

<table>
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<th>Date &amp; Time</th>
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
PARTOGRAPH

Name:     W/o:  Age:  Parity:  Reg. No:

Date & Time of Admission     Date & Time of ROM:

A) Foetal Condition

<table>
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<th>Foetal heart rate</th>
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Amniotic fluid

B) Labour

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Alert

Action

Contractions per 10 min

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C) Interventions

Drugs and IV fluids given

D) Maternal Condition

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Temp (°C)

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Needs referral to FRU for: (if applicable)

Date and time of delivery:

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Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTS L: • IM Oxytocin 10 U
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Name and Signature of Trainer/Supervisor:

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Date of Admission: 
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Past Medical History:

Family History:

GPE

- Pulse: Pallor
- Blood Pressure: Oedema
- RR: Icterus
- Temp: 

3.9.1
Systemic Examination:

CVS
RS

Per Abdomen : Fundal Height
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FHS
Any other observation

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Status of membranes Absent □ Present □
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### Amniotic fluid

### Labour

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### Interventions

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### Maternal Condition

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<td>Registered/Unregistered:</td>
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<td>Complaints:</td>
<td>Amenorrhea</td>
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<td>Pain Abdomen since:</td>
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<td>Bleeding P/V:</td>
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<td>Watery discharge P/V:</td>
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<td>Any other complaints:</td>
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<td>Menstrual History:</td>
<td>Regular/Irregular Cycles</td>
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<td>LMP:</td>
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<td>EDD:</td>
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<td>Obstetric History:</td>
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<tr>
<th>Order of delivery</th>
<th>Mode of delivery-normal/instrumental/LSCS</th>
<th>Complication if any</th>
<th>Outcome of the pregnancy-live birth/stillbirth</th>
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Past Medical History:

Family History:

GPE

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<td>Pallor</td>
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<tr>
<td>Blood Pressure</td>
<td>Oedema</td>
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<td>RR</td>
<td>Icterus</td>
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<td>Temp</td>
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</table>
Systemic Examination:

CVS
RS

Per Abdomen : Fundal Height
Presentation
Uterine Contractions
FHS
Any other observation

Vaginal Examination :
Cervical effacement
Cervical dilation
Status of membranes
Absent ☐ Present ☐
Station of presenting part:
Colour of liquor

Pelvic Assessment :
Adequate/not adequate

Diagnosis :

Investigations :
Hb
Urine
Blood Group & Rh
Any other
In Latent Phase:

<table>
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<tr>
<th>Date &amp; Time</th>
<th>Pulse</th>
<th>BP</th>
<th>Contractions</th>
<th>FHS</th>
<th>PV</th>
<th>Advice</th>
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* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
**PARTOGRAPH**

**A) Foetal Condition**

- Foetal heart rate:
  - 200
  - 190
  - 180
  - 170
  - 160
  - 150
  - 140
  - 130
  - 120
  - 110
  - 100
  - 90
  - 80

**B) Labour**

- Cervix (cm):
  - 10
  - 9
  - 8
  - 7
  - 6
  - 5
  - 4

**C) Interventions**

- Drugs and IV fluids given:

**D) Maternal Condition**

- Pulse and BP:
  - 180
  - 170
  - 160
  - 150
  - 140
  - 130
  - 120
  - 110
  - 100
  - 90
  - 80
  - 70
  - 60

**Temp (°C)**

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).
Needs referral to FRU for (if applicable):

Date and time of delivery:

Delivery Notes

Mother:
- Mode of delivery: Normal □ Assisted □ LSCS □
- Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL:
- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse
BP
Uterus Contracted & Retracted
Bleeding PV

Placenta & Membranes:
- Complete/Incomplete

Baby:
- Sex: M □ F □
- Cried immediately/Resuscitation needed
- Colour: Pink/Blue/Pale
- Tone: Normal/Flaccid
- Weight:
- Urine: Passed/not passed
- Meconium: Passed/not passed
- Congenital anomalies: Yes/No
  If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
INSTRUMENTAL DELIVERY

Outlet Forceps Delivery/Ventouse:

Name & Age :
Registration No. :
Indication :
Pre-Requisites :

Outcome of delivery :

Identification and repair of any tears/lacerations :

Post partum notes:
PR
BP
P/A tone of uterus
bleeding PV

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:
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Name and Signature of Trainer/Supervisor:
Date:
MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS
IN POSTNATAL WARD

Name: __________________________________ Date of Examination: _______________________________

Date and time of Birth: _____________________

Birth Weight: _____________________________ Temperature: ___________ °C/°F

ASK: Does the mother or infant have any problem? _____________________________________

ASSESS:

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ASK THE MOTHER
- Have you started breast feeding the baby?
- Is there any difficulty in feeding the baby?
- Do you have any pain while breast feeding?

If yes, then look for:
- Flat or inverted nipples or sore nipples
- Engorged breasts or breast abscess
- Have you given any other foods or drinks to the baby?

If Yes, what and how?

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- Count the breaths in one minute: ___________ breaths per minute
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- Look for severe chest in drawing
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules. Are there 10 or more pustules or a big boil?
- Measure axillary temperature (if not possible, feel for fever or low body temperature):
  - Normal (36.5–37.4° C)
  - Mild hypothermia (36.0–36.4° C/cold feet)
  - Moderate hypothermia (32.0° C – 36.0° C/cold feet and abdomen)
  - Severe hypothermia (< 32° C)
  - Fever (> 37.4° C/feels hot)
- See if young infant is lethargic or unconscious.
- Look at young infant’s movements. Less than normal?
- Look for jaundice. Are the palms and soles yellow?
- Has the infant had convulsions?
### ASSESS BREASTFEEDING

- Has the infant breastfed in the previous one hour?  
  If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

- Is the infant able to attach? To check attachment, look for:
  - Chin touching breast
  - Mouth wide open
  - Lower lip turned outward
  - More areola above than below the mouth

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- **Classify:**
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- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  - **Classify:**
    - Not suckling at all
    - Not suckling effectively
    - Suckling effectively

- If not suckling well, then look for: ulcers or white patches in the mouth (thrush).

### HAS THE YOUNG INFANT RECEIVED

- Vitamin K
- BCG, OPV 0, HEP-B 1

### Assess other Problems:

### Advice at

- Discharge

### Follow Up:

### Danger Signs:

### Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS
IN POSTNATAL WARD

Name: __________________________________ Date of Examination: __________________________________

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Birth Weight: _________________________ Temperature: ________ °C/°F

ASK: Does the mother or infant have any problem? _____________________________________

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- Is the infant able to attach? To check attachment, look for:
  - Chin touching breast: Yes___ No___
  - Mouth wide open: Yes___ No___
  - Lower lip turned outward: Yes___ No___
  - More areola above than below the mouth: Yes___ No___

- Classify:
  - No attachment at all
  - Not well attached
  - Good attachment

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  - Classify:
    - Not suckling at all
    - Not suckling effectively
    - Suckling effectively

- If not suckling well, then look for: ulcers or white patches in the mouth (thrush).

### HAS THE YOUNG INFANT RECEIVED

- Vitamin K
- BCG, OPV 0, HEP-B 1

### Assess other Problems:

### Advice at

- Discharge

### Follow Up:

### Danger Signs:

### Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS
IN POSTNATAL WARD

Name: __________________________________ Date of Examination: _______________________________

Date and time of Birth: __________________________

Birth Weight: _____________________________ Temperature: __________ °C/°F

ASK: Does the mother or infant have any problem? _____________________________________

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- Has the infant breastfed in the previous one hour?
  If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

- Is the infant able to attach? To check attachment, look for:
  - Chin touching breast
  - Mouth wide open
  - Lower lip turned outward
  - More areola above than below the mouth

**Classify:**
- **No attachment at all**
- **Not well attached**
- **Good attachment**

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
**Classify:**
- **Not suckling at all**
- **Not suckling effectively**
- **Suckling effectively**

- If not suckling well, then look for: ulcers or white patches in the mouth (thrush).

### HAS THE YOUNG INFANT RECEIVED

- Vitamin K
- BCG, OPV 0, HEP-B 1

### Assess other Problems:

### Advice at

- Discharge

### Follow Up:

### Danger Signs:

## Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:
MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS
IN POSTNATAL WARD

Name: __________________________ Date of Examination: ____________________________

Date and time of Birth: _______________________

Birth Weight: ___________________________ Temperature: __________ °C/°F

ASK: Does the mother or infant have any problem? ________________________________

ASSESS:

CHECK FOR FEEDING PROBLEM

ASK THE MOTHER

• Have you started breast feeding the baby?
 • Is there any difficulty in feeding the baby?
 • Do you have any pain while breast feeding?

If yes, then look for:

• Flat or inverted nipples or sore nipples
• Engorged breasts or breast abscess
• Have you given any other foods or drinks to the baby?

If Yes, what and how?

CHECK FOR DANGER SIGNS

• Count the breaths in one minute: _______ breaths per minute
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- Vitamin K
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**Assess other Problems:**

**Advice at**

- Discharge

**Follow Up:**

**Danger Signs:**

**Assessment Grading (Satisfactory/Unsatisfactory)**

Name and Signature of Trainer/Supervisor:

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<tr>
<td>Flat or inverted nipples or sore nipples</td>
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<tr>
<td>Engorged breasts or breast abscess</td>
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<tr>
<td>• Have you given any other foods or drinks to the baby?</td>
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<tr>
<td>If Yes, what and how?</td>
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<tr>
<th>CHECK FOR DANGER SIGNS</th>
<th>Observation</th>
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<tr>
<td>• Count the breaths in one minute: ____________ breaths per minute</td>
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<tr>
<td>Repeat if fast, note down ____________ breaths per minute</td>
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<tr>
<td>• Look for severe chest in drawing</td>
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<tr>
<td>• Look at the umbilicus. Is it red or draining pus?</td>
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<tr>
<td>• Look for skin pustules. Are there 10 or more pustules or a big boil?</td>
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<tr>
<td>• Measure axillary temperature (if not possible, feel for fever or low body temperature):</td>
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<tr>
<td>• Normal (36.5–37.4°C)</td>
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<tr>
<td>• Mild hypothermia (36.0–36.4°C/cold feet)</td>
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<tr>
<td>• Moderate hypothermia (32.0°C – 36.0°C/cold feet and abdomen)</td>
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<td>• Severe hypothermia (&lt; 32°C)</td>
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<tr>
<td>• Fever (&gt; 37.4°C/feels hot)</td>
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<tr>
<td>See if young infant is lethargic or unconscious.</td>
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<tr>
<td>• Look at young infant’s movements. Less than normal?</td>
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<tr>
<td>• Look for jaundice. Are the palms and soles yellow?</td>
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<tr>
<td>• Has the infant had convulsions?</td>
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### ASSESS BREASTFEEDING

- Has the infant breastfed in the previous one hour? If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

- Is the infant able to attach? To check attachment, look for:
  - Chin touching breast
  - Mouth wide open
  - Lower lip turned outward
  - More areola above than below the mouth

  **Classify:**
  - No attachment at all
  - Not well attached
  - Good attachment

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  - **Classify:**
    - Not suckling at all
    - Not suckling effectively
    - Suckling effectively

- If not suckling well, then look for: ulcers or white patches in the mouth (thrush).

### HAS THE YOUNG INFANT RECEIVED

- Vitamin K
- BCG, OPV 0, HEP-B 1

### Assess other Problems:

### Advice at

- Discharge

### Follow Up:

- Danger Signs:

---

**Assessment Grading (Satisfactory/Unsatisfactory)**

**Name and Signature of Trainer/Supervisor:**

**Date:**
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- Pain in abdomen

**Type of Delivery**

**Place and Date of Delivery**

**Time of Delivery**

**Time of initiation of Breast Feeding**

**Examination:**
- Pallor
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Name and Signature of Trainer/Supervisor:

Date:
COMPLICATIONS DURING PREGNANCY

(This exercise will help you to develop your skills in diagnosing obstetric complications and their management. The list of questions in history is long and covers different types of complications. By selecting the relevant ones, you will learn what to ask and look for when examining a patient. This can also be used as a ‘virtual exercise’ if enough cases of complications are not seen during your training period).

History:

During pregnancy:

- a. Bleeding P/V- painless/with pain; duration of amenorrhea when first episode occurred; amount of bleeding; treatment taken; any blood transfused; USG done; any other
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- e. Any other

During delivery

Prolonged labour
Sudden disappearance of labour pains (s/o uterine rupture)
PPH
Home delivery attended by unskilled personnel/TBA/Relative
Retained placenta
Any fits
Sweating, confusion, low BP; loss of consciousness
Perineal tears

Post-partum

Fever, urinary retention/incontinence; constipation/feacal incontinence; pain abdomen; foul smelling lochia; excessive bleeding p/v; breast engorgement; any other

Examination:

GE:
P/A:
P/V:
Final diagnosis

Assessment Grading (Satisfactory/ Unsatisfactory)

Name and Signature of Trainer/Supervisor:
7.2.1

COMPLICATIONS DURING PREGNANCY

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Examination:

- GE:
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Final diagnosis

**Assessment Grading (Satisfactory/ Unsatisfactory)**

Name and Signature of Trainer/Supervisor:
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Name and Signature of Trainer/Supervisor:
WORKBOOK for TRAINING of MEDICAL OFFICERS
in Pregnancy Care and Management of Common Obstetric Complications

Maternal Health Division
Ministry of Health & Family Welfare
Government of India

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August 2009