MINISTRY OF HEALTH - ETHIOPIA

Health Centre /Clinic/Hospital
Integrated Management of New born and Childhood Illness Register (from 0-2 months)

_____ _____ _____ _____ _____
Region **Zone/Subcity/Woreda** **Health Facility Name** **Begin Date** **End Date**

INSTRUCTION ON HOW TO COMPLETE THE UNDER-FIVE REGISTER

1. A row separated by a hard line is for one patient. The very top row indicates which variable to fill, like *name of patient, age, sex, weight, etc….*

2. Some boxes are separated by dotted line. In these boxes two variables should be written. Example: in the first column, the first box is divided into two by dotted line. According to the very top row, in the upper box the *date of the visit* should be filled and in the lower box the *serial number* should be filled. The same applies for the third, fourth and fifth columns. In the third column *name* above and *address* below, in the fourth column *age* above and *sex* below, in the fifth column *weight* above and *temperature* below.

3. In the *presenting complaint* box the most important reason/s for the visit should be written clearly.

4. In the *patient's signs and symptom* boxes all signs or symptoms the child has should be circled or written.

5. Write clearly in the columns for *other problem, classification/s, medicine/s, referral, follow-up and other remarks*.

6. Use all the information you noted to classify the child and provide medicine/s, referral or follow-up.

7. Do follow up to all sick young infants and children and document the outcome of your efforts

8. Write the diagnosis **(name and code)** based on Ethiopia Simplified Version International Classification of Disease (ESV_ICD11) as it appears on the hand book Table on computer (do not abbreviation)

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MINISTRY OF HEALTH-ETHIOPIA

Date / Serial No	Medical record (card) No.	Name / Address (Woreda/ Kebele)	Age / Sex	Wt. / Lt / Temp	Presenting Complaint	Presenting Complaint	Birth Asphyxia	Gestational Age — Weight: (First 7 Days)	Signs and Symptoms — Very Severe Disease and Local Bacterial Infection	Jaundice	Diarrhoea	HIV/AIDS
			____ wks / M / F	____ gms / ____ cm / ____ °C			Not breathing / Not crying / Gasping / Breathing / poorly (<30 /min)	Gestational age: <32 wks, 32 - <37 wks, ≥ 37 wks. Weight: <1,500 gms, 1,500 - <2,500gms, ≥ 2500 gms	* unable to feed, * Not feeding well, * Convulsions, * RR ____/min Fast breathing, * Severe chest indrawing, * Umbilicus: Red / Pus draining, * Temp ≥37.5°C (feels hot), <35.5°C (feels cold), * Skin pustules, * Moves only when stimulated, * No Movement when stimulated	* Yellow: - Palms &/or soles, - Face or eyes, - No yellowness. * Age - < 24hr or - 24hr - < 14 days - ≥ 14 days	Yes No. * _____ days, * Blood in the stool, * Moves only when stimulated, * No Movement when stimulated, * Restless/Irritable, * Sunken eyes, * Skin Pinch: Slowly, Very Slowly	HIV test: * Mother: Positive, Negative, unknown. * Child: ANTIBODY Positive, Negative, Unknown. * Child: DNA PCR Positive, Negative, Unknown
			____ wks / M / F	____ gms / ____ cm / ____ . ___ °C			Not breathing / Not crying / Gasping / Breathing / poorly (<30 /min)	Gestational age: <32 wks, 32 - <37 wks, ≥ 37 wks. Weight: <1,500 gms, 1,500 - <2,500gms, ≥ 2500 gms	* unable to feed, * Not feeding well, * Convulsions, * RR ____/min Fast breathing, * Severe chest indrawing, * Umbilicus: Red / Pus draining, * Temp ≥37.5°C (feels hot), <35.5°C (feels cold), * Skin pustules, * Moves only when stimulated, * No Movement when stimulated	* Yellow: - Palms &/or soles, - Face or eyes, - No yellowness. * Age - < 24hr or - 24hr - < 14 dd - ≥ 14 days	Yes No. * _____ days, * Blood in the stool, * Moves only when stimulated, * No Movement when stimulated, * Restless/Irritable, * Sunken eyes, * Skin Pinch: Slowly, Very Slowly	HIV test: * Mother: Positive, Negative, unknown. * Child: ANTIBODY Positive, Negative, Unknown. * Child: DNA PCR Positive, Negative, Unknown
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Signs and Symptoms (Circle/write ...)		Immuniza-tion Status of Infant	Other Problems	Classification	Treatment			Follow up Date	[ESV_ICD11] Diagnosis		Remarks
Feeding Problem (For Breast-feeding)	Development problem		Maternal Danger Signs (< 6wks)		Medicine (Name, Dose, Schedule, Duration)	Counsel the Mother	Referred (Name of HC/ Hosp)	Outcome	Name	Code	
* Any Breastfeeding difficulty * <8 breastfeeds in 24hrs * Switching breast frequently * Not increasing BF during illness * Receives other foods/drinks * Underweight (Wt /Age) * Mouth ulcers/thrush * Mother not breastfeeding * Positioning Good/ Poor * Attachment Good/ Poor/ No * Suckling Good/ Poor/ No * No Feeding Problem / Not UWt	'* Is there any risk factor and/or parental concern related to the child development? Yes No If Yes, _____ Current age milestone/s: Absent: Yes No	Up to date Not up to date Not Started	Yes No Yes No			* Breast feeding * Keep warm * Early ChildDevel-opment (ECD) * When to return		* Improved * Same * Worsened			
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Sx Type	Count	Sx type	Count
Critical cases		Peneumonia Rxed with antibiotic	
VSD cases		Diarrhea treated with ORS and zinc	
LBI cases		Diarrhea Rxed with ORS only	