Haryana Newborn Defect Reporting Form

HNBBD ID_____

Please Tick (✓)mark the appropriate radiobutton (○).

All fields are mandatory

○ Inborn		○ Outborn	
Mother's UHID		Mother's Aadhar	
Baby's Aadhar		Baby's Aadhar enrolment ID	

1. Basic Information

Birth Defect Detected at	○ Labour Room ○ SNCU ○ Post Natal Ward ○ NBSU ○ Others,Specify_____				
Father's Name		Mother's Name			
Address					
Mobile No		Date of Delivery		Place of Delivery	
Mode of Delivery	○ Normal Vaginal ○Forceps Assisted ○ Vacuum Assisted ○ Elective Cesarean ○ Emergency Cesarean				
Pluarity	○ Single ○ Twin ○ Triplet ○ Higher Order				
Gestation Age(weeks & days)		Baby's Weight(gms)			
Head Circumference(cms)		Mother's Age(years)			
Sex	○ Male ○ Female ○ Other				
Parental Consanguinity	○ Yes ○ No ○ Unknown				
Outcome	○ Alive ○ Died ○ Still Birth Fresh ○ Still Birth Macerated				

2. For Outborn Babies (only)

Date of Admission	
Place of Delivery	○ Government Facility ○ Private Facility ○ Community/Home ○ On the way
Delivery Attended by	○ ANM ○ Doctor ○ Midwife ○ Nurse ○ Traditional Birth Attendant ○ Other

3. History of Birth Defects

Previous termination of pregnancy due to birth defects	○ Yes ○ No
Previous Stillbirth	○ Yes ○ No
Previous Spontaneous Abortion(s)	○ Yes ○ No
Birth Defect in Previous Live Birth	○ Yes ○ No
Iron/Folic Acid (during pregnancy/pre-conception)	○ Yes ○ No ○ Unknown
Whether any religious/social medicine taken	○ Yes ○ No

4. Type of Birth Defect(attach photo of Birth defect after consent of Parents/Guardian)

Sr. No	Category of Birth Defect	Name of Birth Defect	Description	ICD 10	Reporting Date	Confirm/Possible

Name & Designation of professional who filled the form	Name _____ , ○ Nurse ○ MO ○ Gynecologist ○ Pediatrician
Confirmed by (Name & Designation)	Name_____ ○ Gynecologist ○ Pediatrician

5.Additional Information/Investigation if any

Indicate what tests have been performed for the fetus/ baby

Chromosomal Analysis (Karyotype)	○ Yes	○ No
Infantogram / Babygram	○ Yes	○ No
2-D Echo	○ Yes	○ No
Ultrasound Abdomen	○ Yes	○ No
Brain MRI	○ Yes	○ No
Any Other Investigation, if any		
ICD Code Verified by	Name _____	Designation_____

I have been informed that photograph of the birth defect identified in my child is being taken.

Signature of Parent/Guardian
Relation with child_____

Signature of verifier_____

Date _____