

Baby's Identification Code		Parents concern before data is collected: Yes No	
Paper form for Intra-hospitalization for the Kangaroo Mother Care (KMC) Programme			
N°	Data Element	Response	N°
1	Is the baby stable to do KMC?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22
2	Start date of KMC (SDK)		23
3	Date of Delivery		24
4	Date of entry into the Hospital		25
5	Last Name/ First Name of baby		26
6	Sex of the baby	<input type="checkbox"/> Animiste <input type="checkbox"/> Others <input type="checkbox"/> Non-Christain	27
7	Last/First name of Mother	<input type="checkbox"/> No Data	28
8	Age of the Mother		29
9	Tel. N° of the Mother		30
10	Marital status of the Mother (Tick the answer)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> A couple <input type="checkbox"/> Non <input type="checkbox"/> No Data	31
11	Profession of the Mother	<input type="checkbox"/> Salary	32
12	Educational Level of the Mother (Tick the answer)	<input type="checkbox"/> Self Employment <input type="checkbox"/> Not employed <input type="checkbox"/> Student <input type="checkbox"/> Housewife	33
13	Qauter were Mother lives		34
14	Ethnic of the Mother		35
15	Religion of the Mother (Tick the answer)	<input type="checkbox"/> Christain <input type="checkbox"/> Muslim <input type="checkbox"/> Animiste <input type="checkbox"/> Others <input type="checkbox"/> Non-Christain <input type="checkbox"/> No Data	36
16	Name of the father		37
17	Tel. N° of the Father		38
18	Profession of the Father (Tick the answer)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> A couple <input type="checkbox"/> Non <input type="checkbox"/> No Data	39
19	Educational Level of the Father	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Non <input type="checkbox"/> No Data	40
20	Stay in same city with HF		41
21	Time travel between home and hospital (in hours)	<input type="checkbox"/> Midwife <input type="checkbox"/> General Practitioner <input type="checkbox"/> Gvneacoloziste <input type="checkbox"/> No Follow up	42
22	Followed-Up by	<input type="checkbox"/> Single Feotus <input type="checkbox"/> Twins <input type="checkbox"/> Triplet <input type="checkbox"/> Quadruplet	43
23	Pregnancy (Tick the answer)		44
24			45
25			46
26			47
27			48
28			49
29			
30	Post Natal Test	Rubella** TOXO** TPHA** HIV** Hépatite B** Syphilis**	
31		GS <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O	
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44	HTA*		
45	Maternal Fever*		
46	RpreM*		
47	RproM*		
48	pp*		
49	VAT*		

Data Element		Response	Discharge from Hospital/Post Nata Follow Up		
No	Data Element	Response	No	Data Element	Response
50	VAT*				
51	IPT *		1	How did the patient get out of the hospital?	<input type="checkbox"/> With Medical Advice <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Others
52	Iron Administered*		2	Gestational age at discharge	
53	Route of Delivery		3	Number of day (s) Resuscitation	
54	Place of delivery		4	Number of Oxygenation days	
			5	ATB*	
55	APGAR SCORE		6	Jaundice *	
			7	Phototherapy*	
	Weight at birth (g)		8	Palour *	
56			9	Cyanose*	
57	H (Height) (cm)		10	Apnea*	
58	Brachial Perimeter (cm)		11	Number of transfusion *	
59	Cranial Perimeter (cm)		12	GERD*	
60	Thoracic Perimeter		13	FENTON/WHO	
61	Gestational Age at Birth		14	Maternal Diet (Tick the answer)	<input type="checkbox"/> BF(Exclusive Breastfeeding) <input type="checkbox"/> AM (Artificial Milk) <input type="checkbox"/> AM & BF <input type="checkbox"/> A (Artificial food, other than milk)
	What method is used in calculating the gestational age (Tick the answer)	<input type="checkbox"/> Ballard <input type="checkbox"/> LMP <input type="checkbox"/> Echography	15	Number of days in Incubator	
62		<input type="checkbox"/> Weight..... <input type="checkbox"/> Height..... <input type="checkbox"/> Cranial Perimeter.....	16	Number of days of Hospitalization	
63	FENTON/ WHO				
64	Entry Diagnosis				

Form Filled By : KMC Nurse/ KMC Doctor  
Name:.....

Form reviewed by: Data Entry clerk  
Name:.....

Date & Signature:.....

Date & Signature:.....

Legend\* (Expected Response)

Yes  
No

Legend\*\* (Expected Response)

Not done  
No data  
N (Negative)  
P (Positive)







**FORM FOR FOLLOW UP AMBULATORY CARE FOR BABIES AT 40 WEEKS, 3,6,9,12, & 18 Months**

S/N	Data Element	Discharge - 40 Weeks	40 Weeks - 3 Months	3 Months - 6 Months	6 Months - 9 Months	9 Months - 12 Months
		DATE: .....	DATE: .....	DATE: .....	DATE: .....	DATE: .....
1	Chronological Age					
2	Corrected Age					
3	Height					
4	Weight					
5	Crainial Perimeter					
6	Food type					
7	Who came with the baby ? (at 40weeks)					
8	Age of exit from KMC (at 40 weeks)					
9	Pathology					
10	Medicine***					
11	Test Infanib**					
12	Test de Griffiths (QD)					
13	Others					
14	Re-Hospitalization					
15	Why?					

Form Filled By : KMC Nurse/ KMC Doctor

Name: .....

Date & Signature: .....

Form reviewed by: Data Entry clerk

Name: .....

Date & Signature: .....

<b>Legend* (Expected Response)</b>	<b>Legend** (Expected Response)</b>	<b>Legend*** (Expected Response)</b>
BF (Exclusive breastfeeding)	Normal	Multivitamines
AM (Artificial Milk)	Abnormal	Iron
AIM (Artificial Milk)	Transitoire	Anti-reflux
		Xanthine