नेपाल सरकार
स्वास्थ्य तथा जनसंख्या मन्त्रालय
स्वास्थ्य सेवा विभाग
स्वास्थ्य व्यवस्थापन सूचना प्रणाली

Client Personal Profile: Manual Vacuum Aspiration Service

HMIS 3.7 Reg. Number:.. Date of Visit:..

Facility Name:... Province/ District..

1. Personal History

Name and caste .... Age: ....

Education.................................. Contact No: ....

Palika:............................... □Rural Municipality □ Municipality □ Metropolitan City Ward no: ....

2. Medical/Surgical history

Medical history/serious health problems: □ Asthma □Porphyria □TB □Diabetes □ Other........................

Are you taking any medicine? □ No
□ Yes If yes, mention the name of medicine....................

Do you have allergy to any medicine? □ No
□ Yes If yes, mention the name of medicine...............

Previous history of Ectopic Pregnancy: □ No □ Yes

Previous history of Surgery: □ No
□ Yes If yes, types of surgery and year of surgery....................

Any contraceptive used within this one to six months: □ No
□ Yes If yes, mention the method of FP used...............

3. Gynecological/Obstetrical Information

LMP date: .... Gestation weeks by LMP: .... Obstetric History: G....... P....... A......... L ......

Last 6 months menstrual cycle: □ Regular □ Irregular Signs and symptoms of pregnancy: □ Yes □ No

4. General /Physical Examination and Investigation

Blood pressure: .... Pulse: .... Temperature: .... Respiration Rate: ....

Jaundice: □ Yes □ No Pallor: □ Yes □ No

Lungs sound: □ Clear □ Abnormal sound Heart sound: □ Normal □ Abnormal

Abdominal tenderness: □ Yes □No Abdominal mass palpable: □ Yes □ No

Uterus palpable: □ Yes □ No If palpable, size of the uterus..............

Investigations (If required): Urine Pregnancy test........... Hb and Blood group (If anemic on inspection) ....

Ultrasound (report to be attached if USG conducted) ....

5. Pelvic Examination (Speculum and Bimanual Examination)

Vulva: □ Normal □ Abnormal Vaginal discharge: □ Normal □ Abnormal If abnormal, foul smelling: □ Yes □No

P/S examination: Cervix: □ Normal □ Abnormal Unhealthy cervix: □ Yes □ No

P/V examination: Uterine size (weeks).................. Position: □ A/V □ R/V Fornix clear: □ Yes □ No

6. Manual Vacuum Aspiration and Contraceptive Service

Medication given: □Ibuprofen 400 mg □ Diazepam 5-10 mg

□ Antibiotic--Doxycycline/ Azithromycin/ Metronidazole □Para cervical block (1 % Lidocaine)

Size of cannulas used: .... Amount of blood loss (ml.): ....

POC findings: Villi seen: □ Yes □ No □Scanty Sac Seen: □Yes □No Fetal parts seen: □Yes □No

Post procedural findings:

Blood pressure: .... Pulse: .... Temperature: .... Respiration Rate: ....

Abdomen □ Non-tender □Tender

□ Non-guarding □ Guarding Vaginal bleeding: □Scanty □Moderate □Heavy

Any Complication : □ No □ Yes (if yes, mention the type) □ Heavy bleeding requiring Blood transfusion

□ Infection requiring hospitalization/IV Antibiotics

□ Uterine/ abdominal injury requiring laparotomy

Outcome of Complication: □Treated and discharged.

□Referred out (Name of the referred facility) ....

Contraceptive provided: □ Minilap □NSV □Implant □ IUCD

□Depo Provera □Pills □Condom □None □Others...............

Name of Service Provider:.............. **Signature:..............** **Provider Listed No. ....**

Name of Assistant:.............. **Signature:.......................**

7. Follow Up (to be filled if follow up is done)

Follow up: □ in-person □ telephone

Date of follow up: ...... /...... /.......

Blood pressure: .... Pulse: .... Temperature: .... Respiration Rate: ....

PA tenderness: □ Yes □ No

P/S Examination: Vaginal discharge: □ Normal □ Foul smelling Hanging POC: □ Yes □ No

Bleeding: □Yes □ No Fornix clear: □ Yes □ No

P/V Examination: Uterine size (weeks).............. OS Closed: □ Yes □ No

Other relevant finding (if any): ....

Status on Follow up: □ Complete □Incomplete □Ongoing pregnancy □Ectopic pregnancy

Any complication: □ No □ Yes (if yes, mention the type) □ Heavy bleeding requiring Blood transfusion

□ Infection requiring hospitalization/IV Antibiotics

□ Uterine/ abdominal injury requiring laparotomy

Mention the **management or referral** conducted (with name of the referral facility). **Please write in the note section at the end of the form**

Contraceptive provided on follow up: □Minilap □NSV □Implant □IUCD

□ Depo Provera □ Pills □ Condom □ None □Others..........

8. Client Consent Form

अनुसूची १२

(नियम १८ को उपनियम (१) सँग सम्वन्धित)

सेवाग्राहीले दिने मञ्जुरीनामाको ढाँचा

सुरक्षित गर्भपतन सेवाको आवश्यकता, गर्भपतनका विविध प्रविधि, गर्भपतन सेवामा अन्तर्निहित जोखिम, त्यसका विकल्पहरु र यसबाट हुने फाइदा, बेफाइदा लगायतका प्राविधिक एवं व्यवहारिक पक्षमा पूर्ण परामर्श प्राप्त भएकोले सेवा प्राप्त गर्न सुरक्षित मातृत्व तथा प्रजनन स्वास्थ्य अधिकार नियमावली, २०७७ को नियम १८ को उपनियम (१) बमोजिम सम्बन्धित गर्भवती महिला वा निजको संरक्षक वा माथवरको हैसियतले यो मञ्जुरीनामा लेखी तपाई .... स्वास्थ्य संस्था वा स्वास्थ्यकर्मीलाई दिएको छ ।

मञ्जुरीनामा दिने

सेवाग्राहीको-	**संरक्षक वा माथवरको -**
नाम, थर: ठेगाना: उमेर: मिति: दस्तखत: औंठा छाप: बायाँ दायाँ	नाम, थर: ठेगाना: उमेर: मिति: दस्तखत: औंठा छाप: बायाँ दायाँ

दस्तखत:

Notes: