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

Client Personal Profile: Second Trimester Abortion 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 □ Hypertension □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 C/S □ No □ Yes If yes,year of C/S ……
Other Surgery (Specify): □ No
□ Yes If yes, types of surgery and year of surgery ……

Any contraceptive used within last 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: ……

Physical examination: 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 □ Unhealthy

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

6. Screening for the indication for providing second trimester abortion service

A. Maternal condition

i. Physical health

Please write diagnosis: ……

ii. Mental health (please mark if the symptoms are due to current pregnancy at least 3 needed for mental indication

के तपाईलाई निन्द्रा पर्न साह्रै गाह्रो पर्दछ ?	□ छ	□ छैन
के तपाईलाई जतिखेर पनि निन्द्रा लागिरहन्छ वा धेरै सुत्नुहुन्छ ?	□ लाग्छ	□ लाग्दैन
के तपाई ज्यादै थकित महशुस गर्नुहुन्छ र तागत कम भएको जस्तो लाग्छ ?	□ लाग्छ	□ लाग्दैन
के तपाई आफैलाई सधैँ हिनतावोध भएको महशुस गर्नुहुन्छ वा आफु काम नलाग्ने वा जहिले पनी आफु गलत भएको जस्तो अनुभव गर्नुहुन्छ ?	□ हुन्छ	□ हुदैन
के तपाईलाई ध्यान केन्द्रित गर्न, स्पष्टसंग विचार गर्न अथवा निर्णय लिन गाह्रो हुन्छ ?	□ हुन्छ	□ हुदैन
के तपाईलाई उत्तेजित हुने, मन स्थिर नहुने अथवा झर्कोलाग्ने हुन्छ ?	□ हुन्छ	□ हुदैन
के तपाईलाई रमाईलो लाग्ने वा मनोरन्जन दिने अवसरहरूमा सरिक हुन मन लाग्दैन?	□ लाग्छ	□ लाग्दैन
के तपाईलाई आफ्नो जीवन अर्थहिन वा वेसहरा भएको जस्तो लागेको छ ?	□ छ	□ छैन
के तपाईलाई आफ्नो अर्को बच्चालाई आर्थिक, मानसिक वा शारिरीक रूपले धान्न सक्दिन जस्तो लाग्छ ?	□ लाग्छ	□ लाग्दैन
के तपाईलाई यो गर्भले आफ्नो शिक्षा अथवा विकासका अवसरहरूलाई अप्ठेरो पार्छ जस्तो लाग्छ ?	□ लाग्छ	□ लाग्दैन
के यो गर्भ पर पुरूषबाट रहन गएको जस्तो लाग्छ ?	□ लाग्छ	□ लाग्दैन

Signature of Client: ……....Signature of History Taker: ……..……..

iii Rape / Incest

यदि महिलाले आफुलाई जवर्ज स्ती करणी वा हाडनाता करणी गरेको विवरण दि एमा सो वि वरण ठि क हो भनि दस्तखत गर्ने ।

Signature of Client: ……

iv. Infected with virus that deteriorates immune system (e.g. HIV) or suffering from any similar incurable disease.

B. Fetal indication (USG report need to be attached mandatory to the CPP)

Please check the condition that applies:

□ IUFD □Fetal Malformation/ Anomaly □Other condition (e.g. Genetic disorder): ……

7. D&E Procedure Record Section

A. Cervical preparation

1. Misoprostol 400 mcg Route: □S/L □ Buccal □Vaginal

1st Dose date/ Time: …… Repeat Dose (if needed) Date Time: ……
Assessment finding: …… Assessment finding: ……

2. Switched to medical Induction (If applicable):□No □ Yes
If Yes, reason for switch to Medical Induction ……

B. Pain management and antibiotic (half an hour before the D&E procedure):

1. Tab Ibuprofen 400mg: □ Yes □No Pethidine: □ Yes □No

2. Tab Diazepam 10 mg:□ Yes □No

3. Antibiotic (Doxycycline/Azithromycin/ Metronidazole): □ Yes □No

4. Other pain management or antibiotic provided (Specify if provided):

C. Procedure notes for D & E procedure

Date / Time of service provided: ……

Paracervical block given with 20 ml (1% Lignocaine) : □ Yes □ No

Size of Canula Used: …… Amount of blood Loss (ML) : …… Duration of Procedure: ……

Placenta Checked□Yes □ No Complete□ Yes□No If No Specify ……

Fetal Parts Seen: □ Calvarium□ Spine □Upper Limb □Lower Limb

Fetal Foot Length: …… mm Consistent with …… weeks

8. Medical Induction Procedure Record Section

a. Digoxin provided before proceeding for Medical Induction.□ Yes □ No

Regime of Digoxin (Dose, Date and Time) ……

b. Mifepristone 200 mg Oral Date & Time:……

c. Misoprostol 400 mcg Route:□S/L□Buccal□Vaginal

Dose	Date: DD/MM/YY	Time:	Bimanual assessment findings
1			
2			
3			
4			
5			
Additional Dose required			

Total Dose Misoprostol Given:……

Switched to D&E from MI: □No □Yes If yes, mention the reason: ……..……..

d. Pain management (Tab Ibuprofen 400mg) given: □ Yes □No Repeat Tab Ibuprofen: □Yes □No

e. **Expulsion Of**: Fetus: Date & Time: ……

Placenta: Date & Time: ……..…… Placenta complete: □ Yes □ No

f. **Retained Placenta**: □No□ Yes If Yes,□ Managed by MVA □ Misoprostol 400 mcg

g. Total blood loss approximately (ml)……

h. Fetal Foot Length: ……mm Consistent with …… weeks

9. Post Procedure Recovery Care Finding

Blood pressure: …… Pulse: …… Temperature: …… Respiration Rate: ……

Abdominal tenderness: □ Yes □No Guarding: □Not Present□ Present

Vaginal bleeding more than 500 ml: □Yes □ No No of Pad soakage: ……..

Contraceptive provided: □ Minilap □NSV □Implant □ IUCD

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

Reason of Not Providing Contraceptive Service: ……..

Reason for referral to other Reproductive health service (If referred): ……..

Date and time of Discharge: ……..

Recommended follow up after 2 weeks or earlier (if needed) Date & Time : ……

Name of Service Provider: ……. Signature: ……. Provider listed No: ……..

Name of Assistant: ……. Signature: ……..

10. Severe Complication on MI + D & E (to be filled if complication occurs)

Date and time ……../……../…….

Type of severe complications:

Type of severe complications:
□ Heavy bleeding requiring blood transfusion.
□ Infection requiring hospitalization with IV antibiotics.
□ Uterine/ abdominal injury requiring laparotomy.
□ Other complication (specify) ……
□Outcome of complication:

Outcome of compication:
□ Treated and discharged.
□ Referred out (name of the referred facility & provider):

11. Follow Up Recording Section (to be filled if follow up is done) :

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 F/ up: □Complete □Incomplete

If any sever complication □No □ Yes If yes filled section 10:

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

□Depo Provera □Pills □Condom □None □Others……

Name of Service Provider: ……. Signature: ……..

12. 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:	नाम, थर:
ठेगाना:	ठेगाना:
उमेर:	उमेर:
मिति:	मिति:
दस्तखत:	दस्तखत:
औंठा छाप:	औंठा छाप:
बायाँ / दायाँ	बायाँ / दायाँ

दस्तखत:

Note Section