ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH - ETHIOPIA

Health Centre /Clinic/Hospital

Integrated Management of New born and Childhood Illness Register (2 to 59 Months) Register

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

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MINISTRY OF HEALTH - ETHIOPIA

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

Integrated Management of New born and Childhood Illness Register (2 to 59 Months)

Date Serial No	Medical record (card) No.	Name Address (Woreda/ Kebele)	Age Sex	Weight Height Temp	Presenting Complaint	Patient's Signs and Symptoms If sign present, circle the variables and write figures when needed						
						Check General Danger Signs	**Cough or Difficult Breathing**	**Diarrhoea**	**Fever**	**Ear Problem**	**Check Malnutrition and Anemia**	**Feeding Assessment**
			_____ months **M** **F**	_____ kg _____ cm _____ ° C		**Yes No** '* Unable to drink or Breastfeed * Vomits everything * Convulsion history * Convulsing now * Lethargic/ Unconscious	**Yes No** '* _____ days '* Respiratory rate '_____ /minute Fast Breathing * Chest Indrawing * Stridor * Wheeze * Oxygen Saturation _____ %	**Yes No** * _____days ; * Blood in stool * Lethargic/ unconscious * Restless/ Irritable * Sunken eyes * Unable / drinks poorly * Drinks eagerly/thirsty * Skin Pinch- Very Slowly Slowly	**Yes - Hist / Feel / Temp No** * Malaria Risk - High / Low / No If No, Travel history in 1 month - Yes '* Fever duration _____ days ' If > 7 days, Fever every day '* History of measles within 3 month * Stiff neck *Bulged fontanell (<1yr) * Generalized rash- - Cough / Runny nose / Red eyes * Mouth ulcers / Deep or Extensive * Eye: Pus draining / Corneal clouding * BF : _____	**Yes No** * Ear Pain * Ear discharge _____ days * Pus Draining * Tender Swelling behind the ear	*WFH: <-3Z, -3 to <-2Z, ≥ -2Z * MUAC: <11.5, 11.5 - <12.5, ≥12.5cm * Oedema: +, ++, +++ * Medical complications: Yes/No * Appetite test: Passed Failed Palmar pallor: Severe, Some, No Hgb: _____ gm/dL HCT: _____ %	**Yes No** * Feeding Problem: Yes No '* If Yes, _____ _____ _____ _____
			_____ months **M** **F**	_____ kg _____ cm _____ ° C		**Yes No** '* Unable to drink or Breastfeed * Vomits everything * Convulsion history * Convulsing now * Lethargic/ Unconscious	**Yes No** '* _____ days '* Respiratory rate '_____ /minute Fast Breathing * Chest Indrawing * Stridor * Wheeze * Oxygen Saturation _____ %	**Yes No** * _____days ; * Blood in stool * Lethargic/ unconscious * Restless/ Irritable * Sunken eyes * Unable / drinks poorly * Drinks eagerly/thirsty * Skin Pinch- Very Slowly Slowly	**Yes - Hist / Feel / Temp No** * Malaria Risk - High / Low / No If No, Travel history in 1 month - Yes '* Fever duration _____ days ' If > 7 days, Fever every day '* History of measles within 3 month * Stiff neck *Bulged fontanell (<1yr) * Generalized rash- - Cough / Runny nose / Red eyes * Mouth ulcers / Deep or Extensive * Eye: Pus draining / Corneal clouding * BF :	**Yes No** * Ear Pain * Ear discharge _____ days * Pus Draining * Tender Swelling behind the ear	*WFH: <-3Z, -3 to <-2Z, ≥ -2Z * MUAC: <11.5, 11.5 - <12.5, ≥12.5cm * Oedema: +, ++, +++ * Medical complications: Yes/No * Appetite test: Passed Failed Palmar pallor: Severe, Some, No Hgb: gm/dL HCT: %	**Yes No** * Feeding Problem: Yes No '* If Yes, _____ _____ _____ _____
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Patient's Signs and Symptoms If sign present, circle the variables and write figures when needed				Other Prob-lems	Classification	Treatment, Counsel and Follow Up			[ESV_ICD11] Diagnosis		Remarks
HIV/AIDS	Tuberculosis	Development	Immunization, Vit A and Deworming			Medicine (Name, Dose, Schedule, Duration)	Counsel and Referral	Follow up	Name	Code	
* Mother: Positive Negative Unknown * Child Anti-body: Positive Negative Unknown * Child DNA PCR: Positive Negative Unknown * Br F in last 6 wks: Yes No	* Cough > 14 days '* Fever/night sweats > 14days '* Weight loss or failure to gain '* Contact with PTB patient '* Swelling or discharging wound '* MAM or SAM '* HIV: Pos Neg Unknown '* Gene Xpert/AFB Pos Neg Not Done '* Chest XR: Suggestive NOT Suggestive Not Done	*Is there any risk factors and/or parental concerns related to the child development? Yes No If Yes, _____ _____ _____ '* Current age milestone/s: Absent: Yes No '* Earlier age milestone/s: Absent: Yes No '* Lost previously acquired ability/ies: Yes No	* **Immunization (<24 mth)**: Completed, Upto date, Not Upto date, Defaulted, Not Started, **'* Vitamin A (≥6 mth):** Upto date Not Upto date **'* Albendazole or Mebendazole (≥24 mth):** Upto date Not Upto date	**Yes No**			* Counsel mother: Food Fluid When to return Immediately: * Early Child Development (ECD) * If referred, Name of HC/ Hospital or service if referred to the service in the same institution:: _____ _____ _____ _____	* Follow up date: _____ * Follow up Outcome Improved Same Worsened * Follow up Action:			
* Mother: Positive Negative Unknown * Child Anti-body: Positive Negative Unknown * Child DNA PCR: Positive Negative Unknown * Br F in last 6 wks: Yes No	* Cough > 14 days '* Fever/night sweats > 14days '* Weight loss or failure to gain '* Contact with PTB patient '* Swelling or discharging wound '* MAM or SAM '* HIV: Pos Neg Unknown '* Gene Xpert/AFB Pos Neg Not Done '* Chest XR: Suggestive NOT Suggestive Not Done	*Is there any risk factors and/or parental concerns related to the child development? Yes No If Yes, _____ _____ _____ '* Current age milestone/s: Absent: Yes No '* Earlier age milestone/s: Absent: Yes No '* Lost previously acquired ability/ies: Yes No	* **Immunization (<24 mth)**: Completed, Upto date, Not Upto date, Defaulted, Not Started, **'* Vitamin A (≥6 mth):** Upto date Not Upto date **'* Albendazole or Mebendazole (≥24 mth):** Upto date Not Upto date	**Yes No**			* Counsel mother: Food Fluid When to return Immediately: * Early Child Development (ECD) * If referred, Name of HC/ Hospital or service if referred to the service in the same institution:: _____ _____ _____ _____	* Follow up date: _____ * Follow up Outcome Improved Same Worsened * Follow up Action:			
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Disease type	Count
Pneumonia Rxed with antibiotic	
Diarrhea treated with ORS and zinc	
Diarrhea Rxed with ORS only	

Status	Count by Age	
	0-24 months	25-59 months
DD		
SDD		
NDD		