

[Newborn Care Manual: Contents](#)

The complete examination of a newborn infant consists of:

1. The perinatal history.
2. The physical examination.
3. The assessment of the findings.

TAKING A PERINATAL HISTORY

18-A THE IMPORTANCE OF A PERINATAL HISTORY.

Before examining a newborn infant, it is important to first take a careful perinatal history. The history should be taken from the mother, together with the maternal and infant record. Discussion with the staff who have cared for the mother and infant is also important. The history will often identify clinical problems and suggest what clinical signs to look for during the examination. A general examination is not complete if a history is not taken.

18-B THE SECTIONS OF A PERINATAL HISTORY.

1. THE MATERNAL BACKGROUND.

- (i) The mother's age, gravidity and parity.
- (ii) The number of infants that are alive and the number that are dead. The cause of death and age at death.
- (iii) The birth weight of the previous infants.
- (iv) Any problems with previous infants, e.g. neonatal jaundice, preterm delivery, congenital abnormalities.
- (v) The home and socioeconomic status.
- (vi) Family history of congenital abnormalities.

2. THE PRESENT PREGNANCY.

- (i) Gestational age based on menstrual dates, early obstetric examination and ultrasound examination.
- (ii) Problems during the pregnancy, e.g. vaginal bleeding.
- (iii) Illnesses during the pregnancy, e.g. rubella.
- (iv) Smoking, alcohol or medicines taken.
- (v) VDRL (or RPR) and TPHA (or FTA) results. Treatment if syphilis diagnosed.
- (vi) HIV status.
- (vii) Blood groups.
- (vii) Assessment of fetal growth and condition.

3. LABOUR AND DELIVERY.

- (i) Spontaneous or induced onset of labour.
- (ii) Duration of labour.
- (iii) Method of delivery.
- (iv) Signs of fetal distress.
- (v) Problems during labour and delivery.
- (vi) Medicines given to the mother, e.g. pethidine, antiretroviral therapy.

4. INFANT AT DELIVERY.

- (i) Apgar score and any resuscitation needed.
- (ii) Any abnormalities detected.
- (iii) Birth weight and head circumference.
- (iv) Estimated gestational age.
- (v) Vitamin K given.
- (vi) Placental weight.

5. INFANT SINCE DELIVERY.

- (i) Time since delivery.
- (ii) Feeds given.
- (iii) Urine and meconium passed.
- (iv) Any clinical problems, e.g. hypothermia, respiratory distress, hypoglycaemia.
- (v) Contact between infant and mother.

18-C ASSESSMENT OF HISTORY.

It is a valuable exercise to make an assessment of the potential and actual problems after taking the history and before examining the infant. This helps you to look for important clinical signs that may confirm or exclude problems suggested by the history.

THE PHYSICAL EXAMINATION OF A NEWBORN INFANT**18-D REQUIREMENTS FOR THE EXAMINATION.**

1. Whenever possible the infant's mother should be present. This gives her the chance to ask questions. She can also be reassured by the examination. The examiner should use the opportunity to teach the mother about caring for her infant.
2. A warm environment is essential to prevent the infant becoming cold. The room should be warm or a source of heat must be used e.g. an overhead radiant heater. Prevent draughts of cold air by closing doors and windows. Do not place the infant on a cold table top. Use a towel or blanket if necessary.
3. A good light is important so that the examiner can see the infant well.
4. Wash your hands before examining the infant to prevent the spread of infection.
5. The infant should be completely undressed. A full examination is impossible with the infant partially dressed.

18-E THE ORDER OF EXAMINATION.

The physical examination should always be performed in a fixed order so that nothing is forgotten. Usually the following steps are followed:

1. MEASUREMENTS.

- (i) The infant's **WEIGHT** and **HEAD CIRCUMFERENCE** are measured and recorded.
- (ii) An assessment of the infant's **GESTATIONAL AGE** should be made. If necessary, the weight and head circumference measurements can now be plotted against the gestational age on weight and head circumference for gestational age charts.
- (iii) Often the infant's skin or axillary **TEMPERATURE** is measured at this stage of the examination.

2. GENERAL INSPECTION.

A general inspection is made of the infant, paying special attention to the infant's appearance, nutritional state and skin colour.

3. REGIONAL EXAMINATION.

The infant is examined in regions starting at the head and ending with the feet. The examination of the hips is usually left until last as this often makes the infant cry.

4. NEUROLOGICAL STATUS.

5. EXAMINATION OF THE HIPS.

6. EXAMINATION OF THE PLACENTA (if available).

7. AN ASSESSMENT.

An assessment is made using all the information from the history and the physical examination.

The physical examination of the newborn infant is not easy and requires a lot of practice. The correct method of examination should be taught at the bedside by an experienced doctor or nurse. It is not possible to learn how to examine an infant simply by reading an explanation of the method of examination.

18-F RECORDING THE FINDINGS OF THE PHYSICAL EXAMINATION.

Usually a form is used to remind the nurse or doctor which clinical signs to look for and also to record the results of the physical examination. The important observations needed are listed together with the possible normal and abnormal results. The normal results are given on the left hand side of the form while the abnormal results are given on the right hand side. The normal and abnormal results are separated by a bold vertical line. A tick should be placed in the appropriate blocks to indicate which physical signs are present. At a glance any abnormality will be noticed on a completed examination form as it will be recorded to the right of the solid line.

18-G ASSESSMENT OF THE COMPLETE EXAMINATION.

When the history has been taken and the physical examination completed, an overall assessment of the infant must be made. The examiner must decide whether the infant is normal or abnormal. In addition, a list of the problems identified must be drawn up. The management of each problem can then be addressed in turn. A perinatal history and physical examination are of little value if an assessment is not made.

Figure 18-A. A form used to record the results of the physical examination.

General	Well	Sick			
Appearance	Well nourished	Obese	Wasted	Dysmorphic	
Behaviour	Responsive	Lethargic	Irritable	Jittery	
Colour	Pink	Pale	Plethoric	Cyanosed	
Skin	Normal	Rash	Jaundice	Purpura	Bruises
Odour	Normal	Offensive			
Head shape	Normal	Asymmetrical	Caput	Cephalhaematoma	
Fontanelles	Normal	Bulging	Large		
Sutures	Mobile	Overriding	Fused		
Face	Symmetrical	Asymmetrical	Abnormal		
Eyes	Normal	Small	Large	Slanting	Discharge
Nose	Patent	Blocked			
Mouth	Normal	Smooth philtrum	Cleft lip		
Palate	Normal	Cleft			
Tongue	Normal	Large	Protruding		
Chin	Normal	Receding			
Ears	Normal	Abnormal	Low slung		
Neck	Normal	Swellings	Webbed		
Clavicles	Intact	Swellings	Crepitus		
Nipples	Normal	Accessory			
Respiratory rate	40 – 60/minute	Fast	Slow		
Chest movements	Symmetrical	Asymmetrical	Shallow		
Recession	Absent	Costal	Sternal		
Breath sounds	Quiet	Grunting	Noisy		
Heart rate	120 – 160/minute	Tachycardia	Bradycardia		
Pulses	Present	No femoral			
Arms	Normal	Not moving	Fracture		
Palmar creases	Normal	Single crease			
Fingers	Normal	Polydactyly	Syndactyly	Extra fingers	
Abdomen	Normal	Distended	Scaphoid		
Umbilicus	Normal	Moist	Flare	Bleeding	Meconim stained
Hips	Normal	Dislocated	Dislocatable		
Legs	Normal	Not moving			
Feet position	Normal	Positive deformity	Clubbed		
Toes	Normal	Polydactyly	Syndactyly		
Back	Normal	Scoliosis	Meningocoele	Sacral dimple	Tuft of hair
Genitalia male	Testes descended	Undescended	Fluid hernia	Inguinal hernia	Hypospadias
Genitalia female	Normal	Ambiguous			
Anus	Patent	Imperforate			
Moro reflex	Present and equal	Asymmetrical	Absent		
Sucking reflex	Present	Weak	Absent		
Grasp reflex	Present	Weak	Absent		
Muscle tone	Normal	Hypotonic	Hypertonic		
Cry	Normal	High pitched	Hoarse		

ASSESSMENT: _____

Examined by: _____ **Date and time:** _____

The detailed method of examining a newborn infant should be read by all students but need only be studied by students who work in a level 2 or 3 hospital. The abnormal clinical findings should be demonstrated by a tutor who should also explained the descriptive words used. Most of the abnormal findings listed are discussed in other units.

18-H THE METHOD OF EXAMINATION.

	NORMAL	ABNORMAL
MEASUREMENTS		
Birthweight	2500 g or above. Between 10th and 90th centile for gestational age.	Low birthweight (below 2500 g). Underweight (below 10th centile) or overweight. (above 90th centile) for gestational age.
Head circumference	Between 10th and 90th centile for gestational age.	Small head (below 10th centile) or large head (above 90th) centile for gestational age.
Gestational age	Physical and neurological features of term infants (37-42 weeks).	Immature features in preterm infant (below 37 weeks). Post term infants (42 weeks and above) have long nails
Skin temperature	Abdominal wall (36 - 36,5 ⁰ C) or axilla (36,5 - 37 ⁰ C).	Hypothermia (below 35 ⁰ C).
GENERAL INSPECTION		
Wellbeing	Active, alert.	Lethargic, appears ill.
Appearance	No abnormalities.	Gross abnormalities. Abnormal face.
Wasting	Well nourished.	Soft tissue wasting.
Colour	Pink tongue.	Cyanosis, pallor, jaundice, plethora.

Skin	Smooth or mildly dry. Vernix and lanugo. Stork bite, mongolian spots, milia, erythema toxicum, salmon patches.	Dry, marked peeling. Meconium staining. Petechiae, bruising. Large or many pigmented naevi. Capillary or cavernous haemangioma. Infection. Oedema.
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REGIONAL EXAMINATION

HEAD

Shape	Caput, moulding.	Cephalhaematoma, subaponeurotic bleed. Asymmetry, anencephaly, hydrocephaly, encephalocoele.
Fontanelle	Open, soft fontanelle with palpable sutures.	Full or sunken anterior fontanelle. Large or closed fontanelles. Wide or fused sutures.

EYES

Position		Wide or closely spaced.
Size		Small or abnormal eyes.
Lids	Mild oedema common after delivery.	Marked oedema, ptosis, bruising.
Conjunctivae	May have small subconjunctival haemorrhages.	Pale or plethoric. Conjunctivitis. Excessive tearing when nasolacrimal duct obstructed.
Cornea, iris and lens	Cornea clear, regular pupil, red reflex.	Opaque cornea, irregular pupil, cataracts, no red reflex, squint, abnormal eye movements.

NOSE

Shape	Small and upturned.	Flattened in oligohydramnios.
Nostrils	Both patent. Easy passage of feeding catheter.	Choanal atresia. Blocked with dry secretions.
Discharge		Muroid, purulent or bloody secretions.

MOUTH

Lips	Sucking blisters.	Cleft lip. Long smooth upper lip in fetal alcohol syndrome.
Palate	Epstein's pearls.	High arched or cleft palate.
Tongue	Pink.	Cyanosed, pale, or large.
Teeth	None at birth.	Extra or primary teeth.
Gums	Small cysts.	Tumours.
Mucous membranes	Pink, shiny.	Thrush, ulcers.
Saliva		Excessive if poor swallowing or oesophageal atresia.
Jaw	Smaller than in older child.	Very small.

EARS

Site	Ears vertical.	Low set ears.
Appearance	Familial variation.	Skin tag or sinus. Malformed ears. Hairy ears.

NECK

Shape	Usually short.	Webbing, torticollis.
Masses	No palpable lymph nodes or thyroid.	Cystic hygroma. Goitre. Sternomastoid tumour.
Clavicle		Swelling or fracture.

BREASTS

Appearance	Breast bud at term 5 to 10 mm. Enlarged, lactating breasts.	Extra or wide spaced nipples. Mastitis.
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HEART

Pulses	Brachial and femoral pulses easily palpable. 120 - 160 beats per minute.	Pulses weak, collapsing, absent, fast or slow or irregular.
Capillary filling time	Less than 4 seconds over chest and peripheries.	Prolonged filling time if infant cold or shocked.
Blood pressure	Systolic 50 to 70 mm at term.	Hypertensive or hypotensive.
Precordium	Mild pulsation felt over heart and epigastrium.	Hyperactive precordium.
Apex beat	Heard maximally to left of sternum.	Heard best in right chest in dextrocardia.
Murmurs	Soft, short systolic murmur common on day 1	Systolic or diastolic murmurs.
Heart failure		Oedema, hepatomegaly, tachypnoea or excessive weight gain.

LUNGS

Respiration rate	40-60 breaths per minute. Irregular in REM sleep. Periodic breathing with no change in heart rate or colour.	Tachypnoea above 60 breaths per minute. Gaspings. Apnoea with drop in heart rate, pallor or cyanosis.
Chest shape	Symmetrical.	Hyperinflated or small chest.
Chest movement	Symmetrical.	Asymmetrical in pneumothorax and diaphragmatic hernia.

Recession	Mild recession in preterm infant.	Severe recession in respiratory distress.
Grunting		Expiratory grunt in respiratory distress.
Stridor		Inspiratory stridor a sign of upper airway obstruction.
Percussion	Resonant bilaterally.	Dull with effusion or haemothorax. Hyperresonant with pneumothorax.
Air entry	Equal air entry over both lungs. Bronchovesicular.	Unequal or decreased.
Adventitious sounds	Transmitted sounds.	Crackles, wheeze or rhonchi.
ABDOMEN		
Umbilicus	2 arteries and 1 vein.	1 artery, 1 vein. Infection. Bleeding or discharge. Hernia. Exomphalos.
Skin		Periumbilical redness or oedema.
Shape		Distended or hollow.
Liver	Palpable 1 cm below costal margin, soft.	Enlarged, firm, tender.
Spleen	Not easily felt.	Enlarged, firm.
Kidneys	Often felt but normal size.	Enlarged, firm.
Masses	No other masses palpable. Full bladder can be percussed.	Palpable mass.
Bowel sounds	Heard immediately on auscultation.	Few or absent.
Anus	Patent.	Absent or covered.

Stools	Meconium passed within 48 hours of birth. Yellow stools by day 5. Breastfed stool may be green and mucoid.	Blood in stool. White stools in obstructive jaundice. Offensive watery stools.
SPINE		
Appearance	Coccygeal dimple or sinus. Straight spine.	Sacral dimple or sinus. Scoliosis. Meningomyelocele.
GENITALIA		
Penis	Urethral opening at centre of glans.	Hypospadias.
Testes	Descended by 37 weeks.	Undescended.
Scrotum	Well formed at term.	Inguinal hernia. Fluid hernia.
Vulva	Skin tags, mucoid or bloody discharge.	Fusion of labia.
Clitoris	Uncovered in preterm or wasted infants.	Enlarged in adrenal hyperplasia.
Urine	Passed in first 12 hours.	Poor stream suggests posterior urethral valve.
ARMS		
Position	Flexed position in term infant.	Brachial palsy.
HANDS		
Appearance		Extra, fused or missing fingers. Skin tags. Single palmar crease. Hypoplastic nails.
LEGS		
Appearance	Mild bowing of lower legs common.	Dislocatable knees in breech.

FEET

Appearance	Positional deformation.	Clubbed feet. Abnormal toes.
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NEUROLOGICAL STATUS

Behaviour	Alert, responsive.	Drowsy, irritable.
Position	Flexion of all limbs at term.	Extended limbs or frog position in preterm and ill infants.
Movement	Active. Moves all limbs equally when awake. Stretches, yawns and twists.	Absent, decreased or asymmetrical movement. Jittery or convulsions.
Tone		Decreased or increased.
Hands	Intermittently clenched.	Permanently clenched.
Cry	Good cry when awake.	Weak, high pitch or hoarse cry.
Vision	Follows a face, bright light or red object.	Absent or poor following.
Hearing	Responds to loud noise.	No response.
Sucking	Good suck and rooting reflexes after 36 weeks gestation.	Weak suck at term.
Moro reflex	Full extension then flexion of arms and hands. Symmetrical.	Absent, incomplete or asymmetrical response.

HIPS

Movement	Click common. Fully abducted.	Dislocated or dislocatable. Limited abduction.
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18-I EXAMINATION OF THE HIPS.

The hips must be examined in all newborn infants to exclude congenital dislocation or an unstable hip.

The infant is examined lying supine (back on the bed) with the hips flexed to a right angle and knees flexed.

BARLOWS TEST demonstrates both a dislocated and a dislocatable (unstable) hip: One hand immobilizes the pelvis (thumb over pubic ramus, fingers over sacrum) while the other hand moves the opposite thigh into mid-abduction. If the hip is dislocatable, backward pressure on the inner side of the thigh with the thumb on the inner side of the thigh causes the femoral head to slip backwards out of the acetabulum. Conversely forward pressure on the outer side of the thigh with the fingers would tend to cause the head to spring forwards, back into the acetabulum. The same procedure is then carried out for the opposite side.

ORTOLANI TEST for a dislocated hip: Both thighs are held so that the examiner's fingers are over the outer side of each thigh (greater trochanter) and his thumbs rest on the inner side of each thigh (lesser trochanter). Both thighs are then abducted. If a hip is dislocated, a "clunk" can be felt and heard as the femoral head slips forward into its normal position in the acetabulum.

18-J EXAMINATION OF THE PLACENTA

Every placenta should be carefully examined after birth as this can provide valuable information about the infant. Usually the gross placental weight is measured and recorded (placenta, membranes and umbilical cord). As gestation progresses the weight of the placenta increases. An infant of 3000 g usually has a placenta weighing about 600 g (between 450 and 750 g). Therefore, at term the gross placental weight is about a seventh that of the fetus. Infants who are underweight for gestational age have both an absolutely and relatively small placenta. In contrast, infants of poorly controlled diabetics, and infants who have suffered a chronic intrauterine infection (e.g. syphilis) or fetal hydrops have placentas that weigh more than expected.

There are three layers to the placental membranes. The amnion on the inside (prevents the fetus sticking to the membranes), the chorion in the middle (to provide strength), and the decidua on the outside. The amnion is usually smooth and shiny. If the healthy amnion is peeled away from the rest of the membranes, it is completely, clear and transparent. A cloudy or opaque amnion suggests infection (chorioamnionitis) while a granular surface (amnion nodosum) suggests too little amniotic fluid (oligohydramnios). The membranes should not smell offensive.

The umbilical cord normally has one large vein and two thick walled arteries. The more the pull (e.g. when a cord is relatively short due to it being wrapped around the fetal neck) the longer the cord will grow. A short cord suggests very poor fetal movement. The cord becomes stained green once the amniotic fluid has been contaminated with meconium for a few hours. A single umbilical artery is associated with congenital malformations. The umbilical vein has one way valves ("false" knots). A true knot may kill the fetus.

The shape of the placenta is not important. Most are oval. Usually the umbilical cord is inserted into the center of the placenta with arteries and veins radiating out in all directions over the chorionic plate. A peripheral insertion is of no clinical importance. However, insertion into the membranes in a low lying placenta can result in severe haemorrhage from a fetal vessel when the membranes rupture (vasa praevia). Arteries always cross over veins. Fetal vessels torn off at the placental edge indicates that an extra piece of placenta has been retained (accessory lobe). Pale patches on the fetal surface are due to fibrin deposits and are not clinically important.

The maternal surface of the placenta is dark maroon in preterm infants but becomes grey towards term. A pale placenta suggests anaemia. Calcification is not important and reflects a good maternal calcium intake. The maternal surface is divided into lobes (cotyledons). Make sure that the placenta is complete as a retained lobe can result in postpartum haemorrhage or infection. Firmly attached blood clot, especially if it lies over an area of compressed placenta, suggest placental abruption. Fresh infarcts are best identified on palpation as they form a hard lump. Old infarcts are yellow or grey and easily seen, especially if the placenta is sliced. It is of no help to simply describe a placenta as "unhealthy".

It is particularly important to examine the placentas of twins. Unlike-sexed (boy and girl) twins are always non-identical (dizygous). Like-sex twins are definitely identical (monozygous) if they share a single placenta (monochorionic twins). MONOCHORIONIC placentas always have fetal blood vessels on the chorionic plate which run from one umbilical cord to the other. Monochorionic placentas have one chorion and usually two amniotic sacs. Two placentas fused together (DICHORIONIC placentas) may be mistaken for a single placenta. However, there are never fetal blood vessels linking the two umbilical cords. Dichorionic placentas can be seen in both identical and non-identical twins. The separating membranes of dichorionic twins always include both amnion and chorion.

Pathological examination with histology should be requested if an abnormality of the placenta is identified. Placental ischaemia, chronic intrauterine infection and chorioamnionitis are easily identified on histology.

THE ROAD TO HEALTH CARD

Use of the road to health card (preschool health card) is advocated by the World Health Organisation as one of the main methods of improving child health, especially in a developing country. The card is widely used throughout Southern Africa.

After delivery each newborn infant is issued with a road to health card which forms the primary health care record until the infant starts school at the age of 6 years. The infant's mother keeps the card in a plastic cover and should present the card whenever the infant is taken to a clinic or hospital. The infant's perinatal history, growth, immunizations and childhood illnesses are recorded on the card. Usually the infant's HIV status and management is also recorded on the card.

18-J COMPLETING THE ROAD TO HEALTH CARD AFTER DELIVERY.

After delivery the clinic or hospital staff must enter the perinatal details onto the road to health card. The details which are usually entered onto the card are:

1. MATERNAL INFORMATION
 - (i) The mother's name.
 - (ii) The mother's hospital number.
 - (iii) The mother's home address.
2. PREGNANCY AND DELIVERY INFORMATION
 - (i) The duration of pregnancy.
 - (ii) The result of the VDRL or other screening test for syphilis and HIV.
 - (iii) The maternal blood group.
 - (iv) Any pregnancy complications.
 - (v) The method of delivery.
 - (vi) The date and place of birth.
3. NEONATAL DATA
 - (i) The Apgar scores.
 - (ii) The birth weight (mass), head circumference (and sometimes length).
 - (iii) The name and sex of the infant.
 - (iv) The date, infant weight and method of feeding at discharge.

Details of the information recorded on the preschool health card vary slightly from one region to another. Sometimes additional information is also recorded after delivery.

Figure 18-B: The front and back of a Road to Health chart.

VITAMIN A SUPPLEMENTATION

Supplementation age in months	Schedule	Date given	Signature
PROPHYLAXIS			
Mother at delivery (not later than 6-8 weeks)	1 x 300 000 IU		
Infant not breastfed (at 6 weeks)	1 x 300 000 IU		
At 6 months* (up to 1 year)	1 x 100 000 IU		
At 12 - 60 months (with x3)	1 x 300 000 IU every 6 months		

* Allow a period of at least one month between doses

TREATMENT OF :

(NOT if prophylactic dose was given within previous month)

Dose according to following age group: 2-5 years: 50 000 IU
6-11 years: 100 000 IU
12-60 years: 300 000 IU

Percent children	Immediate	1 x	2 x	3 x
Diarrhoea with severe dehydration	1 x			
Malaria	1 x			
Measles	1 x			
Kangakheliasis	1 x			
Severe malnutrition	1 x			

Road to Health Chart

IMPORTANT: always bring this chart when you visit any health clinic, doctor or hospital and present the chart on school entry

Department of Health

Child's name: _____ Sex: boy girl

Child's ID number: _____

Date of birth: ____/____/____ Place of birth: _____

Birth weight: _____ Birth length: _____ Both head circumference: _____

Partners during pregnancy / both / neonatally

APGAR 1 min: _____ Gestational age (wks): _____ Mother's, Delivery: _____

Mother's name: _____

Father's name: _____

Who does the child live with? _____

How many children has the mother had? Number born: _____ Date education given: _____

Reason(s) for death(s): _____

Visual screening

Food test (>6 weeks) Result: L: (yes/no) R: (yes/no) Day tested: ____/____/____

Snellen Chart test: conduct with E-chart (>3 years) Result: L: ____/____ R: ____/____ Day tested: ____/____/____

Hearing screening

Does baby appear to listen when someone is talking or singing? (at 3 months) Result: YES/NO Day tested: ____/____/____

Does baby hear to a loud noise? (at 6 months) Result: L: (yes/no) R: (yes/no) Day tested: ____/____/____

Voice test: Hearing impairment (>12 months) Result: (Normal/Impaired) Day tested: ____/____/____

IMMUNISATIONS

Batch no.	Vaccine	Site	Date given	Signature
	BCG	Right arm		
	Polio 0	Oral		
	Polio 1	Oral		
	DTP 1	Left thigh		
	HBs 1	Left thigh		
	DTP 2/1/2 (combined)	Left thigh		
	1/2/3	Right thigh		
	Polio 2	Oral		
	DTP 2	Left thigh		
	HBs 2	Left thigh		
	DTP 2/1/2 (combined)	Left thigh		
	1/2/3	Right thigh		
	Polio 3	Oral		
	DTP 3	Left thigh		
	HBs 3	Left thigh		
	DTP 3/1/2 (combined)	Left thigh		
	1/2/3	Right thigh		
	Polio 4	Oral		
	DTP 4	Left arm		
	Measles 1	Right arm		
	Polio 5	Oral		
	DTP 5	Left arm		

In need of special care (with x3)

Was the baby less than 2.5kg at birth? YES/NO

Are any brothers or sisters underweight? YES/NO

Is the baby a twin? YES/NO

Is the baby bottle fed? YES/NO

Household TB contact? YES/NO

Does the mother need more family support? YES/NO

Are there any reasons for taking extra care? (for example: single parent etc.) _____

Address of clinic(s) visited

Clinic 1: _____

Clinic 2: _____

