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Banco Interamericano de Desarrollo

Salud Mesoamerica 2015 (SM2015)

Login page for the Health Facility Survey

ID:

Medical Record Review
Please note that all the questions in this section refer to the measurements and procedures performed on the child, unless specified otherwise

1. Today's Date:
(DD/MM/YYYY)

2. Interviewer ID 1:

3. Interviewer ID 2:

4. What type of medical unit is this?
(CHOOSE ONE):
- Health Clinic / Health Post / Mobile Unit
- Community Hospital
- Regional Hospital

5. District ID:
- Orange Walk
- Corozal District
- Cayo District
- Other

6. Facility ID:
- Orange Walk Town / Northern Regional Hospital
- Orange Walk Town / Orange Walk Health Center (Urban)
- San Jose Village / Zenobia Meggs Health Center
- San Felipe Village / San Felipe Health Center
- August Pine Ridge Village / August Pine Ridge Health Center
- Guinea Grass Village / Guinea Grass Health Center
- Santa Martha Village / Santa Martha Health Post
- Carmelita Village / Carmelita Health Post
- Lousiana Area, Orange Walk town / Lousiana Health Post (non functioning due to infrastructure)
- Fireburn Village / Fireburn Health Post (non functioning due to infrastructure)
- San Lazaro Village / Ignacia Moguel Health Post
- San Carlos Village / San Carlos Health Post
- Indian Church Village / Indian Church Health Post
- San Antonio Village / San Antonio Health Post
- San Roman Village / San Roman Health Post
- Orange Walk Town / Mobile Clinic
- Corozal Town / Corozal Community Hospital
- Corozal Town / Corozal Health Center (Urban)
- San Narciso Village / San Narciso Health Center

- ○ Caledonia Village / Caledonia Health Center
- ○ Libertad Village / Libertad Health Center
- ○ Sarteneja Village / Sarteneja Health Center
- ○ Progresso Village / Progresso Health Center
- ○ Chunox Village / Chunox Health Post
- ○ Concepcion Village / Concepcion Health Post
- ○ San Joaquin Village / San Joaquin Health Post
- ○ Xaibe Village / Xiabe Health Post
- ○ Chan Chen Village / Chan Chen Health Post
- ○ Copper Bank Village / Copper Bank Health Post
- ○ San Victor Village / San Victor Health Post
- ○ Corozal Town / Mobile Clinic
- ○ Belmopan City / Western Regional Hospital
- ○ Belmopan City / Belmopan Health Center (Urban)
- ○ Valley of Peace Village / Valley of Peace
- ○ Cotton Tree Village / Cotton Tree Health Post
- ○ St Matthews Village / St Matthews Health Post
- ○ Franks Eddy Village / Franks Eddy Health Post
- ○ Santa Martha /St Margaret Village / Santa Martha Health Post (St Margaret)
- ○ Belmopan City / Mobile Clinic
- ○ San Ignacio / San Ignacio Community Hospital
- ○ San Ignacio / San Ignacio Health Center (Urban)
- ○ Benque Viejo Del Carmen / Mopan Clinic Health Center
- ○ Georgeville / Georgeville Health Center
- ○ San Antonio Village / San Antonio Health Post
- ○ San Ignacio / Mobile Clinic
- ○ Other (specify): _____

7. Please note if date of admission is recorded:
   - ○ Date: _____ (DD/MM/YYYY)
   - ○ Not recorded

8. Please note if hour of admission is recorded
   - ○ Time: _____ (HH:MM)
   - ○ Not recorded

Neonatal Complications

9. Did the baby have the following complications?
   - ☐ Sepsis
   - ☐ Low birth weight
   - ☐ Birth asphyxia
   - ☐ Prematurity
   - ☐ None of the above

This file is ineligible. You indicated that the admission date was **.** Please check records with birth dates between 01/05/2012- 30/07/2014.

10. Age of the child
    - ○ Age in minutes: _____
    - ○ Age in hours: _____
    - ○ Age in days: _____
    - ○ Age in months: _____
    - ○ Age in years: _____
    - ○ Not recorded

11. Age of the mother
    - ○ Age: _____
    - ○ Not recorded

12. Mother's education
    - ○ None
    - ○ Primary
    - ○ Secondary
    - ○ University

- ○ Not recorded

13. Mother's marital status
- ○ Married
- ○ Common law wife
- ○ Single
- ○ Divorced
- ○ Widow
- ○ Other (specify): ____
- ○ Not recorded

14. Please note if date of birth is recorded
- ○ Yes: ____ (DD/MM/YYYY)
- ○ Not recorded

15. Please note hour of birth is recorded
- ○ Time: ____ (HH:MM)
- ○ Not recorded

16. Please note if gestational age is recorded
- ○ Age: ____ weeks
- ○ Not recorded

17. Please note if gender is recorded
- ○ Boy
- ○ Girl
- ○ Twin girls
- ○ Twin boys
- ○ Twins, boy and girl
- ○ Not recorded

18. Did the mother have the following complications? (Select all that apply)
- ☐ Pre-eclampsia
- ☐ Eclampsia
- ☐ Sepsis
- ☐ Hemorrhage
- ☐ Other
- ☐ No complications
- ☐ Not recorded

Please note if the following was done for the patient with septicemia

19. Was the baby ever evaluated by a doctor?
- ○ Yes
- ○ No

Please record if the following checkups were done. Record the value, date and time of the first checkup.

20.

	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Respiratory rate			per minute		
Temperature			°C		
Other (specify) ____					
Other (specify) ____					
Other (specify) ____					

Please note f the following assessments were recorded. Record date and time of the first assessment.

21.

	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Skin color			

Distal temperature (example: distal coldness)			
Abdominal examination			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record date and time of the first test

22.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count			
Neutrophil morphology			
Platelets			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

23.	Recorded (yes/no)	Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)					

24. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- No recorded

25. Date of evaluation by doctor:
- Date: (DD/MM/YYYY)
- Not recorded

26. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

Please check if the following medications were administered and record dosage, date and time of first administration

27.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin		mg/kg		
Gentamicin		mg/kg		
Other antibioltics (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

28. Were any of the above mentioned medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

29. Was the baby ever evaluated by a doctor?
- ○ Yes
- ○ No

Please record if the following checkups were done. Record the value, date and time of the first checkup.

30.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Pulse		per minute		
Respiratory rate		per minute		
Temperature		°C		
Other (specify)				
Other (specify)				
Other (specify)				

Please note if the following assessments were done. Record date and time of the first assessment.

31.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Skin color			
Distal temperature (example: distal coldness)			
Abdominal examination			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record date and time of the first test

32.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Neutrophil morphology			
Platelets			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

33.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count		x10^9 liter		
C reactive protein		mg/dL		
Erythrocyte sedimentation rate		mm/h		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were done and record the value, date and time of the first test

34.	Recorded (yes/no)	Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)

Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)					

35. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- Not recorded

36. Date of evaluation by doctor:
- Date: (DD/MM/YYYY)
- Not recorded

37. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

Please check if the following medications were administered and record the dosage, date and time of first administration

38.

	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin		mg/kg		
Gentamicin		mg/kg		
Other antibiotics (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

39. Were any of the above mentioned medications administered at the same time during this hospitalization?
- Yes
- No
- Not recorded

Please note if the following was done for the patient with low birth weight

40. Was the baby ever evaluated by a doctor?
- Yes
- No

41. Please check the method of gestational age assessment (select all that apply)
- FUM
- ECO
- Ballard test
- Head circumference
- Other
- Not recorded

Please record if the following checkups were done. Record the value, date and time of the first checkup.

42.

	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Pulse		per minute		
Respiratory rate				

		per minute			
Temperature			°C		
Weight			gr		
Length			cm		
Head circumference			cm		
Downes score					
Silverman score					
Other (specify)					
Other (specify)					
Other (specify)					

Please record if the following assessments were done. Record the date and time of the first assessments.

43.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Skin color			
Abdominal examination			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

44.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level		%		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were done and record the value, date and time of the first test

45.		Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)		Recorded (yes/no)			

46. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- Not recorded

47. Date of evaluation by a doctor:
- Date: (DD/MM/YYYY)
- Not recorded

48. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

49. Please check if the following procedures were done (select all that apply)

- ☐ Oxygen mask
- ☐ Oxygen hood
- ☐ Oxygen CAAP
- ☐ Mechanical ventilation
- ☐ Kept in incubator
- ☐ Other
- ☐ Not recorded

50. Please check how the baby was fed

- ○ Breastfeeding
- ○ IV feeding
- ○ Other
- ○ Not recorded

51. Was the baby ever evaluated by a doctor?

- ○ Yes
- ○ No

Please record if the following checkups were done. Record the value, date and time of the first checkup.

52.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Respiratory rate			per minute		
Temperature			°C		
Weight			g		
Length			cm		
Head circumference			cm		
Downes score					
Silverman score					
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were done and record the value, date and time of the first test

53.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level			%		
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were done and record the value, date and time of the first test

54.	Recorded (yes/no)	Negative	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia				mg/dL		
Other (specify)						

Other (specify)

Other (specify)

55. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- Not recorded

56. Date of evaluation by doctor:
- Date: (DD/MM/YYYY)
- Not recorded

57. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

58. Please check if the following procedures were done (select all that apply)
- Oxygen mask
- Oxygen hood
- Oxygen CAAP
- Mechanical ventilation
- Kept in incubator
- Other
- Not recorded

59. Please check how the baby was fed
- Breastfeeding
- IV feeding
- Other
- Not recorded

Please note if the following was done for the patient born prematurely

60. Was the baby ever evaluated by a doctor?
- Yes
- No

61. Please check the method of gestational age assessment (select all that apply)
- FUM
- ECO
- Ballard test
- Head circumference
- Other
- Not recorded

Please check if the following checkups were done and record values, date and time of the first checkup

62.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Hour (HH:MM)
Pulse			per minute		
Respiratory rate			per minute		
Temperature			°C		
Weight			kg		
Length			cm		
Head circumference			cm		
Downes score					
Silverman score					
Other (specify)					

Other (specify)

Other (specify)

Other (specify)

Please record if the following assessments were done. Record date and time of the first assessments.

63.

	Recorded (yes/no)	Date (DD/MM/YYYY)	Hour (HH:MM)
Skin color			
Abdominal examination			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

64.

	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level		%		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were done and record the value, date and time of the first test

65.

	Recorded (yes/no)	Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)					

66. Was the baby evaluated by a doctor at the time of admission?

- ○ Yes
- ○ No
- ○ Not recorded

67. Date of evaluation by doctor:

- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

68. Time of evaluation by doctor:

- ○ Time: (HH:MM)
- ○ Not recorded

69. Please check if the following procedures were done (select all that apply)

- ☐ Oxygen mask
- ☐ Oxygen hood
- ☐ Oxygen CAAP
- ☐ Mechanical ventilation
- ☐ Kept in incubator
- ☐ Other
- ☐ Not recorded

70. Please check how the baby was fed

- ○ Breastfeeding
- ○ IV feeding
- ○ Other
- ○ Not recorded

71. Was the baby ever evaluated by a doctor?

- ○ Yes
- ○ No

Please record if the following checkups were done. Record the value, date and time of the first checkup.

72.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Respiratory rate			per minute		
Temperature			°C		
Weight			gr		
Length			cm		
Head circumference			cm		
Downes score					
Silverman score					
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were done and record the value, date and time of the first test

73.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level			%		
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were done and record the value, date and time of the first test

74.	Recorded (yes/no)	Negative	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia				mg/dL		
Other (specify)						
Other (specify)						
Other (specify)						

75. Was the baby evaluated by a doctor at the time of admission?

- ○ Yes
- ○ No
- ○ Not recorded

76. Date of evaluation by doctor:

- ○ Date: [ ] (DD/MM/YYYY)
- ○ Not recorded

77. Time of evaluation by doctor:
- ○ Time: [ ] (HH:MM)
- ○ Not recorded

78. Please check if the following procedures were done (select all that apply)
- ☐ Oxygen mask
- ☐ Oxygen hood
- ☐ Oxygen CAAP
- ☐ Mechanical ventilation
- ☐ Kept in incubator
- ☐ Other
- ☐ Not recorded

79. Please check how the baby was fed
- ○ Breastfeeding
- ○ IV feeding
- ○ Other
- ○ Not recorded

Please note if the following was done for the patient with asphyxia

80. Was the baby ever evaluated by a doctor?
- ○ Yes
- ○ No

Please record if the following checkups were done for new born baby. Record the value, date and time of the first checkup.

81.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Respiratory rate			per minute		
Temperature			°C		
Downes Score					
Silverman score					
APGAR score in 1 min					
APGAR score in 5 min					
Other (specify)					
Other (specify)					
Other (specify)					

Please record if the following assessments were done. Record date and time of the first assessments.

82.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Skin color			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

83.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count			x 10^9/liter		
Hemoglobin			g/dL		
			x		

Platelets		10^9/L		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were done and record the value, date and time of the first test

84.	Recorded (yes/no)	Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)					

85. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- Not recorded

86. Date of evaluation by doctor:
- Date: (DD/MM/YYYY)
- Not recorded

87. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

88. Did the baby have the following:
- Apnea
- Meconium
- Other (specify)
- Not recorded

89. Please check if the following procedures were done (select all that apply)
- Oxygen Mask
- Oxygen Hood
- Oxygen CAAP
- Mechanical ventilation
- Kept in incubator
- Positive pressure ventilation
- 100% oxygen
- Suctioning of secretions
- Other
- Not recorded

Please check if the following medications were adminsitered and record dosage, date and time of first administration

90.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin		mg/kg		
Gentamicin		mg/kg		
Other antibiotics (specify)		mg/kg		
Other medications (specify)		mg/kg		

Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

91. Were any of the above mentioned medications administered at the same time during this hospitalization?
- Yes
- No
- Not recorded

92. Was the baby ever evaluated by a doctor?
- Yes
- No

Please record if the following checkups were done. Record the value, date and time of the first checkup.

93.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse		per minute			
Respiratory rate		per minute			
Temperature			°C		
Downes score					
Silverman score					
Other (specify)					
Other (specify)					

Please record if the following assessments were done. Record date and time of the first assessments.

94.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Skin color			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were done and record the value, date and time of the first test

95.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level			%		
Leukocyte count		x10 ^9/liter			
Platelets			x 10 ^9/liter		
Hemoglobin		g/dL			
C reactive protein		mg/dL			
Erythrocyte sedimentation level		mm/h			
Blood culture					
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were done and record the value, date and time of the first test

96.	Recorded

	(yes/no)	Negative	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Glycemia			mg/dL		
Other (specify)					
Other (specify)					
Other (specify)					

97. Was the baby evaluated by a doctor at the time of admission?
- Yes
- No
- Not recorded

98. Date of evaluation by doctor:
- Date: (DD/MM/YYYY)
- Not recorded

99. Time of evaluation by doctor:
- Time: (HH:MM)
- Not recorded

100. Was chest radiography done?
- Yes
- No
- Not recorded

101. Please check if the following procedures were done (select all that apply)
- Oxygen mask
- Oxygen hood
- Oxygen CAAP
- Mechanical ventilation
- Kept in incubator
- Other
- Not recorded

Please check if the following medications were adminsitered and record dosage, date and time of first administration

102.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin		mg/kg		
Gentamicin		mg/kg		
Other antibiotics (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

103. Were any of the above mentioned medications administered at the same time during this hospitalization?
- Yes
- No
- Not recorded

104. Disposition:
- Death in hospital
- Discharged home
- Discharged to a family member's house

- ○ Transferred to another facility
- ○ Left after baby completed treatments
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify): _____
- ○ Not recorded

105. SEPSIS

Reason for the baby's referral:

- ☐ High temperature
- ☐ High leukocyte
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Other
- ☐ Not recorded

106. LOW BIRTH WEIGHT

Reason for baby's referral:

- ☐ High temperature
- ☐ High leukocyte
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Low birth weight
- ☐ Low Downes score
- ☐ Low Silverman score
- ☐ Low oxygen saturation level
- ☐ Other
- ☐ Not recorded

107. PREMATURITY

Reason for the baby's referral:

- ☐ High temperature
- ☐ High leukocyte
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Low birth weight
- ☐ Low Downes score
- ☐ Low Silverman score
- ☐ Low oxygen saturation level
- ☐ Other
- ☐ Not recorded

108. BIRTH ASPHYXIA

Reason for baby's referral:

- ☐ High temperature
- ☐ Low APGAR score
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Other
- ☐ Not recorded

109. Please check how the baby was transferred (Select ALL that apply):

- ☐ Incubator
- ☐ Oxygen administration
- ☐ Other
- ☐ Not recorded

110. Date of discharge/referral

- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

111. Time of discharge/referral

- ○ Time: [ ] (HH:MM)
- ○ Not recorded

112. Date of death
- ○ Date: [ ] (DD/MM/YYYY)
- ○ Not recorded

113. Time of death
- ○ Time: [ ] (HH:MM)
- ○ Not recorded

114. Enter relevant comments about this section

Only records from hopitals needs to be reviewed for neonatal complications
You indicated the baby did not have any complications. Please review only records of sepsis, asphyxia, prematurity and low birth weight.

You have reached the end of the survey.

Please click the button 'submit' to submit your responses and close the survey. You cannot modify any responses after the survey has been submitted.

If you believe that this page was reached in error, please click 'Previous' and revise your responses as necessary.

Thank you for your time today.