JANANI SURAKSHA YOJANA CARD

(To be filled by ANM/GNM during registration and Antenatal checkup of the pregnant woman)

Please use **CAPITAL** letters.

Date of filling the Application: _____/_____/2010
Name of the Sub Center : _____
Name of the PHC : _____

PART I

1. Applicant's (Pregnant Women) Name: _____
2. Husband's Name : _____
3. Full Address : _____

   _____

   (Please Use Tick Mark) Rural / Urban/ Slums/ TE/ Char/ Hill/
4. Possesses a BPL Card: **YES / NO (Please Tick),**

   if Yes BPL Card No._____ (Enclose a Photocopy)
   if No. any other certification (Enclose a Photocopy)
5. Date & Registration of Pregnant Woman. No. of the Antenatal Register of SC/PHC/CHC:
   Date: _____ Registration No.:_____

   a. Age: _____ b.LMP: _____ c.EDD: _____

   d. Order of pregnancy Para:_____ Gravida:_____

Date of Registration & 1st ANC	**Pallor (Present/ Absent)**	**Height (cm.) & weight (kg.)**	**BP**	**Hb %**	**Urine for Sugar / Albumin**	**ABO and Rh grouping**	**Mamoni Booklet (Y/N)**	**Any Complication in early pregnancy / Remarks**
__/__/___								

Date	**Pallor**	**Weight (kg.)**	**BP**	**Ut fundal height**	**FHS**	**Lie/ presentation**	**Hb %**	**Urine for Sugar / Albumin**	**Any complications/ Referral**
2nd ANC __/__/___									
3rd Visit __/__/___									
4th ANC __/__/___									
Mamoni Incentive	**1st** Instalment of A/c Payee Cheque of **Rs. 500.00** during **2nd ANC [Y/N]** **2nd** Instalment of A/c Payee Cheque of **Rs. 500.00** during **3rd ANC** along with voucher for **referral transport**. **[Y/N]**								
T.T/ IFA	1st Dose(2nd ANC) :Date _____ 2nd dose (after 4-6 week) Date _____ Booster dose Date: _____ , IFA Tablets : 100 /200 tablets (2nd ANC).(Please Tick)								

6. Decision taken for delivery at (Name of the Health Inst.):_____
   (Motivate for institutional Delivery)

Signature & Name of Applicant **Signature & Name of ANM/GNM** **Signature & Name of ASHA**

Part II

Delivery Record

(To be fill up by SN/ANM/MO conducting delivery)

1. Who accompanied the beneficiary to the Health Center? ASHA / Link Worker (Please Tick)

   Name of the ASHA/Link Worker who accompanied:_____

   Village & Sub Center of ASHA/ Link Worker:_____

2. Was the above accredited worker (ASHA/ Link Worker) present with the beneficiary at the time of Delivery and stayed with the beneficiary? : **YES / NO.** (Please tick)
3. Place of delivery. Name of the Health Institution:_____
4. Date and Registration No. of the Delivery Register :_____
5. Date of Delivery :_____. 6. Normal / Assisted / Caesarean (Please Tick)
7. Outcome: Live / Still Birth (Please Tick).
8. Choose to undergo voluntarily sterilization (PPS) just after delivery? **YES/NO** (Please Tick)

   If yes, has the mother received compensation in the health center? **YES / NO** (Please Tick)
9. Mode of transportation of the Applicant to the Health Center from home:_____
   (No. & type of the Vehicle)
10. Any amount paid to the Applicant for transportation? **YES / NO** (Please Tick)
    If Yes, Amount paid (Rs._____)
11. Who paid the amount ?: Name & Designation_____
12. Amount paid by A/c Payee Cheque to the mother as incentive under JSY Scheme and date
    Rs._____ Issue Date of Cheque: _____

    (Under no circumstances JSY incentive be handed over to the ASHA or any other person other than the beneficiary)
13. Amount paid by A/c Payee Cheque to ASHA/Link Worker and date.

    Rs._____ Date of Payment: _____
    If Delayed, reasons_____
14. If delivered in a Health Institution whether Mamata Kit provided to mother as per guideline, [Y / N]
15.

Date of Post Natal Check Up (To be Conducted by ANM and ASHA during Home visit)	**Date**	**General Condition**	**FEVER**	**Bleeding / LOCHIA**	**Complication, if any**	**Referral**
1st Visit(within 48 Hours)						
2nd Visit(within 10 days)						
3rd Visit(within 6 weeks)						

16. Status of new born baby : Weight _____ Kg. (Within first 2 days after delivery)
    Condition of the Cord _____
    (Be kept dry and nothing should be applied on the cord stump)
    Feeding (Breast feeding starting time after delivery_____(in hours)
    Jaundice:- Present / Absent (Please Tick)

Signature & Name of Applicant | **Signature & Name of ASHA/Link Worker** | **Signature & Name of Medical Officer,i/c**

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Disbursement of JSY incentives

For Accounts	Checked with delivery register and found correct PHC Accountant/ BAM (Seal)	Passed for payment of Rs. _____ MO, i/c Institution (Seal)	Received the payment by A/c payee cheque No._____ Dated_____ JSY Beneficiary