

CBA ID no.

Community Based Newborn and Maternal, Child Health Initiative
(CBNB & MCHI)

Form 5: Infant Death From

Date of Visit: _____ Village: _____

Full Name of Mother: _____ Sex of Baby: Male Female

Age of Baby: _____

How many times have you visited this baby? _____

Date of Death: _____

Where did baby die? Home Health Centre other specify _____

If at Health Center ,Name of Health Center: _____

A. Stillbirth (Born dead)

1) Was the baby a stillbirth Yes No

2) If Yes, was it a Macerated Stillbirth or Fresh Stillbirth? _____

B. Neonatal Death (baby was born alive but died before 28 days)

3) On what day after delivery did he baby die? _____

4) If the baby died on the day of delivery, at what time did it die?

Less than 5 minuets less than 30 minuets less than 1 hour After 1 hour

5) Was baby Premature? Yes No

6) What could have caused the death of the baby? _____

7) Was anything done to help baby before death? Yes No

8) What was done to help baby? _____

9) Who gave care to baby? CBA Doctor/nurse Traditional attendant

*MBNama
PI*