Serial No/Code:_____

Home Visit Form

Woman's Name:	Date of Birth (dd/mm/yy):
Community/ Neighborhood:	District:
Phone Number:	Date of Visit:

To be completed for children U5

Child name:_____	Date of Birth:_____	Sex: ☐ Female ☐ Male

To be completed for children U2

Weight at Birth:_____(Kg)	First Initiating of BF following delivery (in hours):_____
Do you breastfeed your child currently? ☐ Yes ☐ No	Is child fed upon demand? ☐ Yes ☐ No
Is child given anything besides your breast milk? ☐ Yes ☐ No • **If Yes**, what is child given:_____ ☐ liquids, ☐ semi solid, ☐solid • At what age (in months) did you start introducing this: _____ • Why complementary feeding was introduced? ☐milk not sufficient, ☐colic, ☐ mother pregnant, ☐ mother works, ☐ other, specify:_____	

Services provided for Child during visit:

Hb Level:_____ ☐ normal ☐ not normal	Weight: ___	Height: ___	Head circumference: ___ ☐Normal ☐ Not Normal	Temperature:___
If child has ARI, what is the respiratory rate:_____	Child Growth: ☐Normal ☐ Not Normal: ☐Underweight ☐ wasting ☐ stunting ☐ others, specify …….			

Childhood respiratory infections and Diarrheal Disease:

Does child suffer from respiratory Infection? ☐ Yes ☐ No, **If Yes:**
Does mother use home remedies: ☐ Yes ☐ No If **Yes**, Specify: _____
Does child suffer from diarrhea? ☐ Yes ☐ No, **If Yes:**
Does mother use home remedies: ☐ Yes ☐ No If **Yes**, Specify: _____

Child general health status:

☐ Disabilities ☐ Hip dislocation ☐ congenital abnormalities ☐ mouth fungal infection ☐ Anemia

Health message delivered during home visit:
Does child require follow up by CHW ☐ Yes ☐ No, Date of follow up visit: _____
Subject of follow up visit:

Is the child in need of referral? ☐ Yes ☐No, Why? _____
Place of Referral? _____

General Notes:(family relations, environment, mother-in-law/ husband influence/ cooperation within family members)

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CHW Name: _____