**Medical Record and Checklist for Female and Male Sterilization**

Name of Health Facility...................................................................................................................................

Beneficiary Registration Number........................................................................................ Date....................

1. **Eligibility Checklist**

|  |  |
| --- | --- |
| Client is within eligible age | Yes......................... No.................... |
| Client is ever married | Yes......................... No.................... |
| Client has at least one child over one year of age | Yes......................... No................... |
| Lab investigations (Hb, urine) undertaken are within normal limits (7.0 gms or more) | Yes......................... No.................. |
| Medical status as per clinical observation is within normal limits | Yes......................... No.................. |
| Mental status as per clinical observation is normal | Yes......................... No.................... |
| Local examination done is normal | Yes......................... No.................... |
| Informed consent given by the client | Yes......................... No..................... |
| Explained to the client that consent form has authority of a legal document | Yes......................... No.................... |
| Abdominal/Pelvic examination has been done in the female and is within normal limits | Yes......................... No................... |
| Infection prevention practices as per laid down standards | Yes......................... No................... |

1. **Menstrual History (for female clients)**

|  |  |
| --- | --- |
| Cycle Days |  |
| Length |  |
| Regularity | Ragular................Irregular................ |
| Date of LMP (DD/MM/YYY) | ................/............../..................... |

1. **Obstetric History (for female clients)**

|  |  |
| --- | --- |
| Number of Spontaneous Abortions |  |
| Number of Induced Abortions |  |
| Currently Lactating | Yes......................... No.......................... |
| Amenorrheic | Yes......................... No.......................... |
| Whether Pregnant | Yes......................... No..........................  If Yes (No. of weeks pregnancy)...... |
| No. of Children | Total No. .......................... |
| Date of Birth of Last Child (dd/mm/yyy) | ................./................/.................. |

1. **Contraceptive History**

|  |  |
| --- | --- |
| Have you or your spouse ever used contraception? | Yes......................... No...................... |
| Are you or your spouse currently using any contraception or have you or your spouse used any contraception during the last six months? | * None..................................... * IUCD...................................... * Condoms ............................... * Oral Pills ................................ * Any Other (specify)................. |

1. **Medical History**

|  |  |
| --- | --- |
| Recent medical IIIness | Yes......................... No.......................... |
| Previous Surgery | Yes......................... No.......................... |
| Allergies to medication | Yes......................... No.......................... |
| Bleeding Disorder | Yes......................... No.......................... |
| Anemia | Yes......................... No.......................... |
| Diabetes | Yes......................... No.......................... |
| Jaundice or liver disorder | Yes......................... No.......................... |
| RTI/STI/PID | Yes......................... No.......................... |
| Convulsive disorder | Yes......................... No.......................... |
| Tuberculosis | Yes......................... No.......................... |
| Malaria | Yes......................... No.......................... |
| Asthma | Yes......................... No.......................... |
| Heart Disease | Yes......................... No.......................... |
| Hypertension | Yes......................... No.......................... |
| Mental IIIness | Yes......................... No.......................... |
| Sexual Problems | Yes......................... No.......................... |
| Prostatitis (Male sterlization) | Yes......................... No.......................... |
| Epididymitis (Male Sterilization) | Yes......................... No.......................... |
| H/O Blood Transfusion | Yes......................... No.......................... |
| Gynecological problems (Female Sterilization) | Yes......................... No.......................... |
| Currently on medication (if yes specify) | Yes......................... No.......................... |

Comments:.............................................................................................................................................................

...............................................................................................................................................................................

**F Physical Examination**

**BP...............................................Pulse...........................................Temperature..............................**

|  |  |
| --- | --- |
| Lungs | Normal..................Abnormal............... |
| Heart | Normal..................Abnormal............... |
| Abdomen | Normal..................Abnormal............... |

**G Local Examination (Strikeout whichever is not applicable)**

1. **Male Sterilization**

|  |  |
| --- | --- |
| Skin of Scrotum | Normal..................Abnormal............... |
| Testis | Normal..................Abnormal............... |
| Epididymis | Normal..................Abnormal............... |
| Hydrocele | Yes......................... No.......................... |
| Varicocele | Yes......................... No.......................... |
| Hernia | Yes......................... No.......................... |
| Vas Deferens | Normal..................Abnormal............... |
| Both Vas Palpable | Yes......................... No.......................... |

1. **Female Sterilization**

|  |  |
| --- | --- |
| External Genitalia | Normal..................Abnormal............... |
| PS Examination | Normal..................Abnormal............... |
| PV Examination | Normal..................Abnormal............... |
| Uterus Position | A/V.......R/V........Midposition........ Abnormal.................... |
| Uterus size | Normal..................Abnormal............... - Size .......... |
| Uterus Mobility | Yes......................... No..........................(Restricted/Fixed) |
| Cervical Erosion | Yes......................... No.......................... |
| Adnexa | Normal..................Abnormal............... |

Comments:-...................................................................................................................................................

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**H Laboratory Investigations**

|  |  |
| --- | --- |
| Hemoglobin Level | ................................................. Gms% |
| Urine: Albumin | Yes......................... No.......................... |
| Urine - Sugar | Present................... Absent ................. |
| Urine test for Pregnancy | Positive .................... Negative ............ |
| Any Other (specify) | .............................................................. |

Name ................................................................ Signature of the Examining Doctor

Date .................................................................. HOSPITAL SEAL

**I. Preoperative Preparation**

|  |  |
| --- | --- |
| Fasting | Yes ....... duration ......... hrs. No ..... |
| Passed urine | Yes .............. No........... |
| Any other (specify) |  |

1. **Anaesthesia/Analgesia**

|  |  |
| --- | --- |
| Type of anaesthesia given   * Tick the option | * Local only Local and analgesia * General, no intubation General,& intubation * Any other (specify) |
| Time |  |
| Drug name |  |
| Dosage |  |
| Route |  |

**Signature of anaesthetist (**in case of regional or general anaesthesia)

1. **Surgical Approach (Strikeout whichever is not applicable)**
2. **Male sterilization**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Local anaesthesia | Lignocaine 2% ........................... cc  Other | | | |
| Technique | Conventional ...................... NSV.......... | | | |
| Type of incision Conventional/NSV | Single vertical ........................ Double vertical ......................... Single puncture | | | |
| Material for occlusion of vas | 2-0 Silk .................... 2-0 Catgut ....................... | | | |
| Fascial interposition | Yes ........................... No ......................  If no, give reasons ................................  .............................................................  ............................................................ | | | |
| Length of vas resected | ..........................................................Cm | | | |
| Suture of skin for conventional vasectomy | Silk ................................. Other ........................................ | | | |
| Surgical notes |  | | | |
| Any other surgery done at time of sterilization? | Yes ................................ No .........................  If yes gives details | | | |
| List all Anesthetic agents,Analgesics,Sedatives and Muscles relaxants | Time | Drug Name | Dosage | Route |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Vital signs during Surgery | Time | BP | Pulse | Resp. Rate |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Duration of Surgery | Time of starting..........................a.m./p.m.  Time of Closure.........................a.m./p.m.  Total time spent.........................min/hrs | | | |
| Specify details of complications and management:- | | | | |

Date : ...............................

Name : ............................................................ Signature of the operating surgeon

1. **Female sterilization**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Local anaesthesia | Lignocaine........................... %  Other | | | |
| Timing of procedure  Tick the option used | * Within 7 days post - partum ................... * Interval (42 days or more after delivery or abortion) * With abortion, induced or spontaneous  1. Less than 12 weeks 2. More than 12 weeks 3. Any other (specify) | | | |
| Technique  Tick the option used | * Minilap Tubectomy   (a)With C section  (b) With other surgery ....................   * Laparoscopy Tubal Occlusion   **SPL/DPL** .................................. | | | |
| Method of occlusion of fallopian tubes  Tick the option used | * Modified Pomeroy Laparoscopy:   (a) Ring  (b) Clip | | | |
| Details of gas insufflation pneumoperitoneum created (CO2/Air)  Tick the option used | Yes ................................ No ..................... | | | |
| Insufflator used | Yes ................................ No ..................... | | | |
| List all Anesthetic agents,Analgesics,Sedatives and Muscles relaxants | Time | Drug Name | Dosage | Route |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Vital signs during Surgery | Time | BP | Pulse | Resp. Rate |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Duration of Surgery | Time of starting..........................a.m./p.m.  Time of Closure.........................a.m./p.m.  Total time spent.........................min/hrs | | | |
| Specify details of complications and management:- | | | | |

Date : ................

Name : ............................................................ Signature of the operating surgeon

1. **Vital Signs: Monitoring Chart (For Female Sterilization)**

\*Sedation: 0-Alert 1- Drowsy 2- Sleeping/arousable 3- Not arousable

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Event | Time | Sedation\* | Pulse | Blood Pressure | Respiratory Rate | Bleeding | Comments (Treatment) |
| Preoperative (every 15 min after premedication) |  |  |  |  |  |  |  |
| Intra-operative (continuous) |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Post-operative  1-Every 15 min for first hour and longer if the patient is not stable/awake | 15 min |  |  |  |  |  |  |
| 30 min |  |  |  |  |  |  |
| 45 min |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| 2-Every 1 hour until 4 hours after surgery | 1 hr |  |  |  |  |  |  |
| 2 hr |  |  |  |  |  |  |
| 3 hr |  |  |  |  |  |  |
| 4 hr |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Date & Time:-...............................................

Name : ............................................................ Signature of the attending Staff nurse

1. **Post-Operative Information**

|  |  |
| --- | --- |
| Passed urine | Yes......................... No.......................... |
| Abdominal distension | Yes......................... No.......................... |
| Patient feeling well | Yes......................... No.......................... |
| If no, please specify |  |

1. **Instruction For Discharge**

|  |  |
| --- | --- |
| Male sterilization client observed for half an hour after surgery | Yes......................... No.......................... |
| Female sterilization client observed for four hours after surgery | Yes......................... No.......................... |
| Post-operative instructions given verbally | Yes......................... No.......................... |
| Post-operative instruction given in writing | Yes......................... No.......................... |
| Patient counselled for postoperative instructions | Yes......................... No.......................... |
| Comments:- | |

Date & Time of discharge:-.........................................................................................................

Name : ............................................................ Signature of the Discharging doctor

**F**