Rashtriya Bal Swasthya Karyakram (RBSK)

Screening Tool cum Referral Card for Children 6-19 years in schools

Preliminary Particulars							
District / Block		Mobile Health Team ID		Name of School		School ID / DISE code	
Name of Child		Gender (M/ F)		Class / Section		Age (in MM/YYYY)* in completed years & month	
MCTS No. / Unique ID		Name of Mother/ Father/ Guardian		Contact no.		AADHAAR No.	
Weight (in Kg.)	Height/Length (in cm.)	Body Mass Index(Weight (in kg)/ Height2 (in metres2)		BMI classification			
Blood Pressure (Systolic/ Diastolic) (mm Hg)		Acuity of Vision: (Snellen's Chart)		Left Eye:	Right Eye:	Name of Teacher	

Refer job aid for instructions and pictures

	A. Defects at Birth	If Yes, Refer
A1	Look for any visible Defect at Birth in the Child viz Cleft Lip/Palate/Club foot/Down's syndrome/ Cataract etc.	
	B. Deficiency	
B1	**Severe anaemia-** Look for severe palmar pallor	
B2	**Vitamin A Deficiency -** Ask for night blindness/look for Bitot's spot (white patches on sclera)	
B3	**Vitamin D Deficiency –** Look for Wrist Widening/Bowing of legs	
B4	**Goitre -** Any swelling in the neck region	
B5	**Oedema** of both feet	
	C. Diseases	**If Yes, Refer**
C1	**Convulsive Disorders** – Did the child ever have had spells of unconsciousness and fits?	
C2	**Otitis Media** - Did the child have more than 3 episodes of ear discharge in last 1 year?	
	Look for Active discharge from ear	
C3	**Dental Condition** - Look for white demineralized/ brown tooth, Discoloration, cavitation, Swollen/bleeding/ red gums, Visible Plaque/stains	
C4	**Skin Condition** - Does the child c/o itching on skin (especially at night)? Look for round or oval scaly patches/ pustules in finger webs. Any other lesion on the skin.	
C5	**Rheumatic Heart Disease** - Auscultate for Murmur	
C6	**Others [Tuberculosis** – cough > 2 weeks, **Asthma** – More than 3 Episodes of increased shortness of breath and difficult breathing and wheezing in past 6 months.	
	D. Developmental Delays for 6-10 years only **(If answer to any of the following is "YES", Child needs to be referred)**	
D1	Does the child have difficulty in seeing, either during day or night? (without spectacles) **(V)**	
D2	Compared with other children of his/her age, did the child have any delay in walking? **(GM)**	
D3	Does the child have stiffness or floppiness and/or reduced strength in his/her arms or legs? **(GM/NMI)**	
D4	From birth till date, has the child ever had fits, or became rigid, or had sudden jerks or spasms of arms, legs or whole body? Refer if the fits are uncontrolled **(Convulsive disorder)**	
D5	Compared to his/her classmates, does the child find it difficult to read or write or to do simple calculations? **(LD)**	
D6	Does the child have any difficulty in speaking as compared to other children of his/her age? **(SP)**	
D7	Does the child have difficulty in hearing? (without hearing aid) **(H)**	
D8	Compared with other children of his / her age, does the child have difficulty in learning new things? **(LD/C)**	
D9	As compared to children of his/her age, does the child have difficulty in sustaining attention on activities at school, home or play? **(ADHD)**	

E. ADOLESCENT SPECIFIC QUESTIONNAIRE (10-19 years) Instruction: Following questions to be asked maintaining audio visual privacy ONLY.		Answer Y/N discretely
E1	Do you always find it difficult to handle things in your life that has resulted from changes occurring in your body? **(If Y, Refer)**	
E2	Are you able to say "NO" and leave the place when your friends pressurize you to smoke or drink with them? **(If N, Refer)**	
E3	Do you feel unduly tired early in the morning or you feel depressed most of the time? **(If Y, Refer)**	
E4	In case of females-Have your menstrual cycles started yet? **(If not by 16 years, Refer)**	
E5	Do you have your periods every months (i.e.28 ± 7 days)? **(If N, Refer)**	
E6	Do you experience any pain or burning sensation while urinating? **(If Y, Refer)**	
E7	Do you have any discharge/ foul smelling discharge from the genitor-urinary area? **(If Y, Refer)**	
E8	Do you feel extreme pain during menstruation so much so that it stops you from doing routine activities/ attend schools? **(If Y, Refer)**	

Preliminary Findings (tick as applicable):

Code	Finding	Code	Finding	Code	Finding	Code	Finding	Code	Finding
Defects at Birth		**Deficiencies**		**Childhood Diseases**		**Developmental delay and disability**		**Adolescent Health concerns**	
1	Neural Tube Defect	10	Anaemia	15	Skin Conditions	21	Vision Impairment	31	Growing up concerns
2	Down's Syndrome	11	Vitamin A Deficiency (Bitot Spot)	16	Otitis Media	22	Hearing Impairment	32	Substance abuse
3	Cleft Lip & Palate	12	Vitamin D Deficiency, (Rickets)	17	Rheumatic Heart Disease	23	Neuro-Motor Impairment	33	Feel depressed
4	Talipes (club foot)	13	SAM/Stunting	18	Reactive Airway Disease	24	Motor Delay	34	Delay in menstruation cycles
5	Developmental Dysplasia of Hip	14	Goiter	19	Dental Caries	25	Cognitive Delay	35	Regular periods
6	Congenital Cataract			20	Convulsive Disorders	26	Speech and Language Delay	36	Experience any pain or burning sensation while urinating
7	Congenital Deafness					27	Behaviour Disorder (Autism)	37	Discharge/ foul smelling discharge from the genitor-urinary area
8	Congenital Heart Disease					28	Learning Disorder	38	Pain during menstruation
9	Retinopathy of Prematurity (only at DH)					29	Attention Deficit hyperactivity Disorder		
30	Others (specify)								

Please Circle	**Defects at Birth**		**Deficiency**		**Diseases**		**Developmental delay**		**Adolescent Health concerns**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
If Yes, Refer to	DEIC/DH		CHC/ SAM to NRC		CHC/DH		DEIC		CHC/AFHC	
Referral (Y/N)										
Name and sign of Doctor, MHT			Sign of Teacher				Date of Visit			

**In case the referral has is made for more than one Ds, especially involving the DEIC, the child must be referred to DEIC first*