



नेपाल सरकार  
स्वास्थ्य तथा जनसंख्या मन्त्रालय  
स्वास्थ्य सेवा विभाग  
स्वास्थ्य व्यवस्थापन सूचना प्रणाली

### Client Personal Profile: Medical Abortion Service

HMIS 3.7 Reg. Number:.....

Date of Visit:.....

Facility Name:.....

Province/ District:.....

### 1. Personal History

Name and caste .....

Age: .....

Education.....

Contact No: .....

Palika:..... ☐ Rural Municipality ☐ Municipality ☐ Metropolitan City

Ward no: .....

### 2. Medical/Surgical History

Medical history/serious health problems:

☐ Asthma ☐ Porphyria ☐ TB ☐ Diabetes ☐ Other.....

Are you taking any medicine?

☐ No ☐ Yes

If yes, mention the name of medicine.....

Do you have allergy to any medicine?

☐ No ☐ Yes

If yes, mention the name of medicine.....

Previous history of Ectopic Pregnancy:

☐ No ☐ Yes

Previous history of Surgery:

☐ No ☐ Yes

If yes, types of surgery and year of surgery.....

Any contraceptive used within this one to six months:

☐ No ☐ Yes

If yes, mention the method of FP used.....

### 3. Gynecological/Obstetrical Information

LMP date: .....

Gestation weeks by LMP: .....

Obstetric History: G..... P..... A..... L .....

Last 6 months menstrual cycle: ☐ Regular ☐ Irregular

Signs and symptoms of pregnancy: ☐ Yes ☐ No

### 4. General /Physical Examination and Investigation

Blood pressure: .....

Pulse: .....

Temperature: .....

Respiration Rate: .....

Jaundice: ☐ Yes ☐ No

Pallor: ☐ Yes ☐ No

Lungs sound: ☐ Clear ☐ Abnormal sound

Heart sound: ☐ Normal ☐ Abnormal

Abdominal tenderness: ☐ Yes ☐ No

Abdominal mass palpable: ☐ Yes ☐ No

Uterus palpable: ☐ Yes ☐ No

if palpable size of the uterus.....

Investigations (If required): Urine Pregnancy test.....

Hb and Blood group (If anemic on inspection) .....

### 5. Pelvic Examination (Speculum and Bimanual examination)

**Vulva:** ☐ Normal ☐ Abnormal

Vaginal discharge: ☐ Normal ☐ Abnormal

If abnormal, Foul smelling: ☐ Yes ☐ No

**P/S examination:** Cervix: ☐ Normal ☐ Abnormal

Unhealthy cervix: ☐ Yes ☐ No

**P/V examination:** Uterine size (weeks).....

Position: ☐ A/V ☐ R/V

Fornix clear: ☐ Yes ☐ No

## 6. Medical Abortion Drugs and Contraceptive Service

Drugs Provided: **Mifepristone** (200mg): Date ..... / ..... / .....

Time .....

**Misoprostol** (200mcg × 4 tablets): ☐ Home ☐ Clinic

Date: ..... / ..... / .....

Time .....

Pain management drugs (400mg ibuprofen × 4 tabs) to take home: ☐ Yes ☐ No

Contraceptive provided (on the day of Mifepristone): ☐ Implant ☐ Depo Provera ☐ Pills

☐ Condom ☐ None ☐ Others.....

Name of Service Provider:.....

Signature:.....

Provider Listed No. ....

## 7. Follow Up ( to be filled if follow up is done )

Follow up: ☐ in-person ☐ telephone

Date of follow up: ..... / ..... / .....

MA success Checklist used: ☐ Yes ☐ No

Blood pressure: .....

Pulse: .....

Temperature: .....

Respiration Rate: .....

PA tenderness: ☐ Yes ☐ No

**P/S Examination:** Vaginal discharge: ☐ Normal ☐ Foul smelling

Bleeding: ☐ Yes ☐ No

Hanging POC: ☐ Yes ☐ No

**P/V Examination:** Uterine size (weeks).....

Fornix clear: ☐ Yes ☐ No

OS Closed: ☐ Yes ☐ No

Other relevant finding (if any): .....

**Status on Follow up:** ☐ Complete ☐ Incomplete ☐ Ongoing pregnancy ☐ Ectopic pregnancy

**Any complication (SAE):** ☐ No ☐ Yes (if yes, mention the type)

☐ Heavy bleeding requiring Blood transfusion

☐ Infection requiring hospitalization/IV Antibiotics

☐ Uterine/ abdominal injury requiring laparotomy

**Mention the management or referral conducted (with name of the referral facility)** .....

**Contraceptive provided on follow up:**

☐ Minilap

☐ NSV

☐ Implant

☐ IUCD

☐ Depo Provera

☐ Pills

☐ Condom

☐ None

☐ Others.....

## 8. Client Consent Form

अनुसूची १२

(नियम १८ को उपनियम (१) संग सम्बन्धित)

## सेवाग्राहीले दिने मञ्जुरीनामाको ढाँचा

सुरक्षित गर्भपतन सेवाको आवश्यकता, गर्भपतनका विविध प्रविधि, गर्भपतन सेवामा अन्तर्निहित जोखिम, त्यसका विकल्पहरु र यसबाट हुने फाइदा, बेफाइदा लगायतका प्राविधिक एवं व्यवहारिक पक्षमा पूर्ण परामर्श प्राप्त भएकोले सेवा प्राप्त गर्न सुरक्षित मातृत्व तथा प्रजनन स्वास्थ्य अधिकार नियमावली, २०७७ को नियम १८ को उपनियम (१) बमोजिम सम्बन्धित गर्भवती महिला वा निजको संरक्षक वा माथवरको हैसियतले यो मञ्जुरीनामा लेखी तपाईं ..... स्वास्थ्य संस्था वा स्वास्थ्यकर्मीलाई दिएको छ । १

### मञ्जुरीनामा दिने

सेवाग्राहीको-	संरक्षक वा माथवरको -
नाम, थर: ठेगाना: उमेर: मिति: दस्तखत: औँठा छाप:	नाम, थर: ठेगाना: उमेर: मिति: दस्तखत: औँठा छाप:
<div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="border: 1px solid black; width: 100px; height: 80px; text-align: center; line-height: 80px;">बायाँ</div> <div style="border: 1px solid black; width: 100px; height: 80px; text-align: center; line-height: 80px;">दायाँ</div> </div>	<div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="border: 1px solid black; width: 100px; height: 80px; text-align: center; line-height: 80px;">बायाँ</div> <div style="border: 1px solid black; width: 100px; height: 80px; text-align: center; line-height: 80px;">दायाँ</div> </div>

दस्तखत:

Notes: