



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

**Client Personal Profile: Manual Vacuum Aspiration 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) .....

Ultrasound (report to be attached if USG conducted) .....

**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 ☐ AbnormalUnhealthy cervix: ☐ Yes ☐ No

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

Position: ☐ A/V ☐ R/VFornix clear: ☐ Yes ☐ No**6. Manual Vacuum Aspiration and Contraceptive Service**Medication given: ☐ Ibuprofen 400 mg☐ Diazepam 5-10 mg☐ Antibiotic--Doxycycline/ Azithromycin/ Metronidazole☐ Para cervical block (1 % Lidocaine)

Size of cannulas used: .....

Amount of blood loss (ml.): .....

POC findings: Villi seen: ☐ Yes ☐ No ☐ ScantySac Seen: ☐ Yes ☐ NoFetal parts seen: ☐ Yes ☐ No**Post procedural findings:**

Blood pressure: .....

Pulse: .....

Temperature: .....

Respiration Rate: .....

Abdomen

☐ Non-tender☐ Tender☐ Non-guarding☐ Guarding

Vaginal bleeding:

☐ Scanty☐ Moderate☐ HeavyAny Complication : ☐ No ☐ Yes (if yes, mention the type)☐ Heavy bleeding requiring Blood transfusion☐ Infection requiring hospitalization/IV Antibiotics☐ Uterine/ abdominal injury requiring laparotomy

Outcome of Complication:

☐ Treated and discharged.☐ Referred out (Name of the referred facility) .....

Contraceptive provided:

☐ Minilap☐ NSV☐ Implant☐ IUCD☐ Depo Provera☐ Pills☐ Condom☐ None☐ Others.....

Name of Service Provider:.....

Signature:.....

Provider Listed No. ....

Name of Assistant:.....

Signature:.....

**7. Follow Up ( to be filled if follow up is done )**Follow up: ☐ in-person ☐ telephone

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

Blood pressure: .....

Pulse: .....

Temperature: .....

Respiration Rate: .....

PA tenderness: ☐ Yes ☐ No

P/S Examination:

Vaginal discharge: ☐ Normal ☐ Foul smellingHanging POC: ☐ Yes ☐ NoBleeding: ☐ Yes ☐ NoFornix clear: ☐ Yes ☐ No

P/V Examination:

Uterine size (weeks).....

OS Closed: ☐ Yes ☐ No

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

Status on Follow up:

☐ Complete☐ Incomplete☐ Ongoing pregnancy☐ Ectopic pregnancy

Any complication:

☐ No ☐ Yes (if yes, mention the type)☐ Heavy bleeding requiring Blood transfusion☐ Infection requiring hospitalization/IV Antibiotics☐ Uterine/ abdominal injury requiring laparotomyMention the **management or referral** conducted (with name of the referral facility). **Please write in the note section at the end of the form**

Contraceptive provided on follow up:

☐ Minilap☐ NSV☐ Implant☐ IUCD

## અનુસૂચી ૧૨

(नियम १८ को उपनियम (१) सँग 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 । ३

## મઝ્જુરીનામા દિને

सेवाग्राहीको-	संरक्षक वा माथवरको -
<p>नाम, थर:</p> <p>ठेगाना:</p> <p>उमेर:</p> <p>मिति:</p> <p>दस्तखत:</p> <p>औंठा छाप:</p> <div> <div>बायाँ</div> <div>दायाँ</div> </div>	<p>नाम, थर:</p> <p>ठेगाना:</p> <p>उमेर:</p> <p>मिति:</p> <p>दस्तखत:</p> <p>औंठा छाप:</p> <div> <div>बायाँ</div> <div>दायाँ</div> </div>

**दस्तखतः**

Notes:

