AAI ONSAI BITHANGKI

Govt. of BTR program

High Risk Pregnancy Referral Form

A. Information of the Pregnant Women (PW)

Details of Pregnant Women (PW)

Full Name :_____ Date of Birth:_____

Husband / Guardian's Name :_____

Address

Revenue Village : _____ VCDC :_____

Block : _____ District :_____

Police Station : _____ PIN :☐☐☐☐☐☐

Subcentre - HWC/Sub-Health Centre/ AAM:_____

Please paste your photo here

Contact Information

Mob. No. Pregnant Women (PW)

☐☐☐☐☐☐☐☐☐☐

Mob. No. Husband / Guardian

☐☐☐☐☐☐☐☐☐☐

B. Referral Provider's Information

Name (Referrer) :_____

Designation :_____ Mob. No. ☐☐☐☐☐☐☐☐☐☐

C. Pregnancy Information

1. LMP (Last Menstrual Period) : _____(DD-MM-YYYY)
2. EDD (Estimated Date of Delivery) : _____(DD-MM-YYYY)
3. Gestational age on the date of examination : _____ Months _____ Weeks.
4. MCP(Mother and Child Protection) card No. :_____

   (MCP/MCTS card to be checked and verified by ASHA/ ANM)
5. Previous Pregnancies:
   - A. Number of previous pregnancies:
   - B. Previous pregnancy outcomes:
     - b.1) No. of abortions (< 28 weeks) :_____
     - b.2) No. of stillborn (> 28 weeks) :_____
     - b.3) No. of living children :_____ (Boys: _____ Girls: _____)
6. Relevant Medical History
   - A. Pre-existing conditions :_____
   - B. Prior surgeries :_____

D. Bank Details of Pregnant Woman

1. Name as in Bank Account : _____
2. Account Number : _____
3. Bank Name : _____
4. Branch Name : _____
5. IFSC Code : _____

(To be checked and verified by ASHA/ANM)

Signature of Pregnant Women
Name :
Date :
Place :

Signature of Husband / Guardian
Name :
Date :
Place :

E. Current Pregnancy Concerns/ Complications *(Tick any of the below for reason to suspect HRP)*

- ☐ Severe Anaemia *(Blood Hb <7gm%).*
- ☐ High BP *(>140/90 mmHg).*
- ☐ Pre-Eclampsia *(High BP as above with Urine Proteins+).*
- ☐ Severe Pre-Eclampsia *(Symptoms like headache, swelling, blurring of vision and BP > 140/110 with Urine Proteins 3+ or 4+).*
- ☐ Eclampsia *(Fits/Convulsions with high BP).*
- ☐ Syphilis/ HIV positive.
- ☐ High Blood Glucose or symptoms of Diabetes mellitus *(more urine, more thirst, more hunger).*
- ☐ Swelling on neck or symptoms of Hypothyroidism *(Increase in weight, thick skin, laziness).*
- ☐ 1st pregnancy with age less than 20 years or more than 35 years.
- ☐ More than 1 baby in abdomen on palpation or by Ultrasound.
- ☐ Malpresentation *(Baby's head not in normal position in uterus).*
- ☐ Caesarean Operation done in earlier delivery.
- ☐ Placenta not in normal position on ultrasound.
- ☐ Bleeding.
- ☐ Still birth/Abortion/Premature birth/Baby with malformation in earlier delivery.
- ☐ Blood Group found Rh Negative.
- ☐ PCOS/PCOD *(PolyCystic Ovary Syndrome/PolyCystic Ovarian Disease).*
- ☐ Other illness found:

_____

_____

F. Reasons for Referral

Note by Referral provider

:_____

_____

(BP, weight, height, any other additional information)

(Please validate MCP Card, Previous test reports in case available)

G. Identity and Address proof documents of Pregnant Woman

1. Provide details of identity card from options mentioned below -
   - ☐ Aadhaar Card. *(Mandatory)*
   - ☐ MCP Card (Mother and Child Protection). *(Mandatory)*
   - ☐ Bank or Post office photo passbook. *(Mandatory)*
   - ☐ Voter ID card.
   - ☐ Ration card.
   - ☐ Caste Certificate.
   - ☐ Any other photo ID card issued by Council/ State/Union Govt
     Identity No.: _____
     (To be checked and verified by ASHA/ANM)

2. Age of pregnant woman (on the date of registration): _____

I hereby declare that all information provided is true and accurate to the best of my knowledge.

DATE OF REG UNDER AOB: ☐☐☐☐☐☐☐☐ **Unique ID of Registration:** ☐☐☐☐☐☐☐☐☐☐☐☐

(Unique ID will be generated after online submission)

Signature of ASHA
Name :
Date :
Place :
Phone No. ☐☐☐☐☐☐☐☐☐☐

Signature of ANM
Name :
Date :
Place :
Phone No. ☐☐☐☐☐☐☐☐☐☐

Acknowledgement
(To be filled by Community Health Officer (CHO)/ Medical Officer (MO))

Mrs._____[name] of _____[village] under _____[sub-health centre/Subcentre-HWC] has submitted a duly filled application form (Form A-02) along with all the mandatory documents.

Mrs. _____ [sur name] is eligible to receive benefits including financial benefits and special monitoring and care under the **Aai Onsai Bithangki** scheme of the Government of the Bodoland Territorial Region.

Her registered Unique ID is: _____ and Date of Registration under AOB is: _____.

Name of MO/CHO :
Date :
Place :

Signature of MO/CHO

The following documents has been checked and authenticated

Sl.	Documents to be enclosed	Check and authenticated (tick)
i)	Identity card of Pregnant Women (PW)	
ii)	Bank passbook showing Name, A/C number, bank name (PW)	
iii)	MCP (Mother and Child Protection)Card (PW)	

Reason(s) for eligibility to receive benefits under the Aai Onsai Bithangki (AOB) scheme
(Note by CHO/MO)

:_____

_____