District Public Health Office

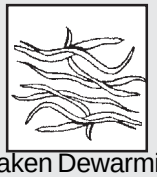
CB-MNC Program

FCHV Form

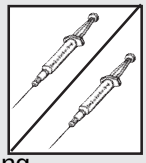
FCHV No:____ FCHV Name: _____ VDC: _____ Ward#:_____

Pregnant Women Name:_____ Oppressed ☐

ANC Period



Taken Dewarming tabs



Taken TT vaccination

Month					
4rth	5th	6th	7th	8th	9th
					

Taken Iron Tablets (30 tabs/month)

Identification of health worker or health institution

Counselling on use of MSC

Received MSC Tablets after 8 months of delivery

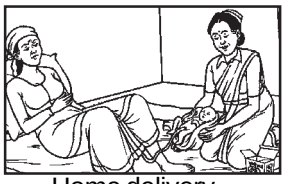
Antenatal Counselling Content Covered

Date of birth

____ Day

____ Month

____ Year



Home delivery assisted by helath worker/delivery at health facility

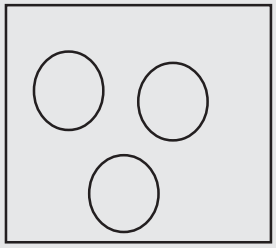
Post-Partum and Newborn Care

FCHV Visited

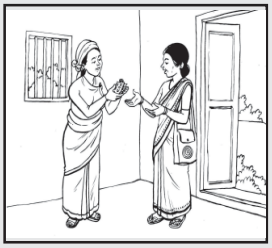
Within 2 days ☐

Beyond 2 days ☐

USE of MSC



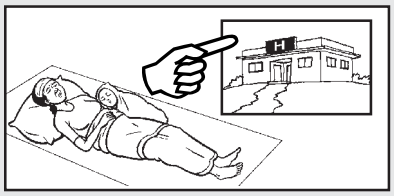
Took all MSC tablets



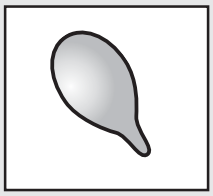
If not taken returned MSC tablets

Heavy bleeding

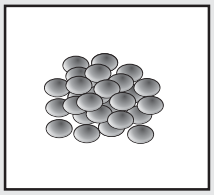
Healthy mother



Mother with danger sign referred



Given Vit A to mother



Given Iron to mother (45 tabs)

Date of form closed:

___day___Month__Year

(Close the form after 8 days of delivery)