Hospital:	
Ward:	

Child Death Data Capture Sheet
Child PIP v4.0
Confidential document

Entered by:	
Date entered:	
Checked:	

Patient name:		Folder no.:		Residential Sub district:	

Date of birth	yyyy-mm-dd	**Age**	**pc auto**	**Sex**	Ⓜ / Ⓕ / Ⓤ	**Re-admission**	Ⓨ / Ⓝ / Ⓤ	**Dead on arrival**	Ⓨ / Ⓝ / Ⓤ

Date of admission	yyyy-mm-dd	**Time of admission**	hh : mm	**When death occurred**	Weekend / Public holiday
Date of death	yyyy-mm-dd	**Time of death**	hh : mm	Weekday (07:00-19:00)	Weeknight (19:00-07:00)	Unknown

Records (include road to health booklet assessment)

1. Folder not available	2. Folder present, records incomplete	3. Folder present, notes inadequate	4. Folder present, records incomplete & notes inadequate	5. Folder available, records & notes OK

Referred

	Name of referring hospital/CHC/clinic:				
Ⓨ / Ⓝ / Ⓤ	**If yes, from:**	1. Another hospital/CHC	2. A clinic	3. Private practitioner	Unknown
	If yes, from:	1. Inside drainage area	2. Outside drainage area	Unknown	

Social

Mother	1. Alive and well	2. Dead	3. Sick	Unknown	**Primary caregiver**	1. Mother	2. Grandmother	3. Father
Father	1. Alive and well	2. Dead	3. Sick	Unknown		4. Other:		Unknown

Nutrition

1. Overweight/obese	2. NAM/Normal	3. MAM	4. SAM	Unknown

HIV

Mother: HIV status	1. Not HIV infected		2. HIV infected: on ART		3. HIV infected: NOT on ART		Unknown
Perinatal ARV	1. Guideline followed		2. Guideline not followed		3. Mother not infected at delivery		Unknown
Feeding in first 6 months	1. Exclusive breast for 6/12		2. No breast, ever		3. Mixed		Unknown
Child: HIV status	1. Not HIV infected		2. HIV exposed (perinatal or ongoing breast milk)		3. HIV infected		Unknown
PCP prophylaxis (cotrimoxazole)	1. Yes	2. Interrupted	3. No (but eligible)		4. No (not HIV infected)		Unknown
ART (child)	1. Yes	2. Interrupted	3. No (but eligible)		4. No (not HIV infected)		Unknown

Causes of Death (insert diagnosis and code)

IMMEDIATE CAUSE (a)	Due to (b)	Due to (c)	Due to (d)
Other significant condition 1		Other significant condition 2		Other significant condition 3

Modifiable Factors (insert codes)

Code	**Ward: Hospital**	Comments	Code	**Referring Facility & Transit**	Comments
			Code	**Clinic/Outpatients**	Comments
Code	**Admissions & Emergency: Hospital**	Comments			
			Code	**Home**	Comments

In your opinion, would this death have been avoidable, overall?

1. Yes	2. Not sure	3. No	Unknown

Would this death have been avoidable at YOUR facility?

1. Yes	2. Not sure	3. No	Unknown

Case Summary/Comments (write summary at time of death, if possible)

Child's details (age, where from, admission date/time)
History of presenting complaint
Relevant background history (including details of HIV and TB)
Examination Weight: Height: MUAC:

Problem List

Problem	Investigations	Progress	Outcome
1.			
2.			
3.			
4.			
5.			

Comments

Completed by (PRINT):	**Checked by (PRINT):**
Date:	**Date:**