

**VERBAL AUTOPSY FORM**  
**Form No. 2: Post Neo-Natal Deaths (29 days to 1 Year)**

CONFIDENTIAL

District: <input style="width: 80%;" type="text"/>	Block: <input style="width: 80%;" type="text"/>	Village: <input style="width: 80%;" type="text"/>
PHC: <input style="width: 80%;" type="text"/>	Sub-Center: <input style="width: 80%;" type="text"/>	MCTS Number of Mother/Baby: <input style="width: 80%;" type="text"/>
Year: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	1 <sup>st</sup> HYS: <input type="checkbox"/>	2 <sup>nd</sup> HYS: <input type="checkbox"/>
Name of Head of Household: <input style="width: 100%;" type="text"/>		
Full name of deceased: <input style="width: 100%;" type="text"/>		
Name of mother of deceased: <input style="width: 100%;" type="text"/>		

**Section 1: Details for Respondent and Deceased**

<p><b>Details of Respondent:</b></p> <p>1. Name of respondent: <input style="width: 100%;" type="text"/></p> <p>2. Relationship of respondent with deceased:</p> <p>1. Brother/Sister: <input type="checkbox"/> 2. Grandfather/Grandmother: <input type="checkbox"/></p> <p>3. Mother/Father: <input type="checkbox"/> 4. Other relative: <input type="checkbox"/></p> <p>5. Neighbour/No relation: <input type="checkbox"/> 99. Unknown: <input type="checkbox"/></p> <p>3. Did the respondent live with the deceased during the events that led to death?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown: <input type="checkbox"/></p>	<p>4. What is the highest standard of education the respondent has completed?</p> <p>0. Illiterate and literate with no formal education: <input type="checkbox"/></p> <p>1. Literate, Primary or below: <input type="checkbox"/> 4. Literate, Class XII: <input type="checkbox"/></p> <p>2. Literate, Middle: <input type="checkbox"/> 5. Graduate &amp; above: <input type="checkbox"/></p> <p>3. Literate, Matric(Class-X): <input type="checkbox"/> 99. Unknown: <input type="checkbox"/></p> <p>5. Category:</p> <p>1. General <input type="checkbox"/> 2. OBC <input type="checkbox"/> 3. ST <input type="checkbox"/> 4. SC <input type="checkbox"/></p>	<p>6. Religion of the head of the household</p> <p>1. Hindu: <input type="checkbox"/> 2. Muslims: <input type="checkbox"/></p> <p>3. Christian: <input type="checkbox"/> 4. Sikh: <input type="checkbox"/></p> <p>5. Buddhist: <input type="checkbox"/> 6. Jain: <input type="checkbox"/></p> <p>7. No religion: <input type="checkbox"/> 8. Others: <input type="checkbox"/></p> <p>99. Unknown: <input type="checkbox"/></p>
<p><b>Details of deceased</b></p> <p>7. Deceased's Sex: 1. Male: <input type="checkbox"/> 2. Female: <input type="checkbox"/></p> <p>8. Age in completed days: less than 1 day <input type="checkbox"/> 01-28 days <input type="checkbox"/></p> <p>9. Date of birth: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> (DD-MM-YYYY)</p> <p>10. Date of death: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> (DD-MM-YYYY)</p> <p>11. House address of the deceased:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>11B. PIN: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p>12 Place of death:</p> <p>1. Home: <input type="checkbox"/> 2. Private Hospital: <input type="checkbox"/> 3. PHC/CHC/Rural Hospital: <input type="checkbox"/></p> <p>4. On way to health facility: <input type="checkbox"/> 5. Medical College: <input type="checkbox"/> 6. Sub Center: <input type="checkbox"/></p> <p>7. District Hospital: <input type="checkbox"/> 8. Other place: <input type="checkbox"/> 99. Unknown: <input type="checkbox"/></p> <p>12. What did the respondent think the newborn died of? (Allow the respondent to tell the illness in his or her own words)</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	

**Section 2: Child Death**

<p>13A. Did s/he die from an injury or accident? 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>13B. If yes, what kind of injury or accident?</p> <p>1. Road traffic injury <input type="checkbox"/> 2. Falls <input type="checkbox"/> 3. Fall of objects <input type="checkbox"/> 4. Burns <input type="checkbox"/></p> <p>5. Drowning <input type="checkbox"/> 6. Poisoning <input type="checkbox"/> 7. Bite/sting <input type="checkbox"/> 8. Natural disaster <input type="checkbox"/></p> <p>9. Homicide/assault <input type="checkbox"/></p>	<p>19B. Did the child receive anything other than breast milk to drink during the first 6 months of life?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>19C. During the illness that led to death, was the child breastfeeding?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p>
<p><b>Details of baby after birth</b></p> <p>19A. When was s/he first breastfed?</p> <p>1. Immediately/within one hour of birth <input type="checkbox"/> 4. Never breastfed <input type="checkbox"/></p> <p>2. Same day child was born <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>3. Second day or later <input type="checkbox"/></p>	<p>25B. If yes, for how many completed days?</p> <p>Less than 1 day <input type="checkbox"/> AND <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> days</p> <p>25C. Was there blood in the stools?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>26A. Did s/he have a cough?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>26B. If yes, for how many completed days?</p> <p>Less than 1 day <input type="checkbox"/> AND <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> days</p> <p>26C. If yes, was there blood?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>27A. Did s/he have breathing difficulties?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>27B. If yes, for how many completed days?</p> <p>less than 1 day <input type="checkbox"/> AND <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> days</p> <p>27C. Did s/he have fast breathing?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p>
<p><b>Details of sickness at time of death</b></p> <p>20A. Did s/he have fever?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>20B. If yes, how many completed days did the fever last?</p> <p>Less than 1 day <input type="checkbox"/> AND <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> days</p> <p>20C. Was the fever accompanied by chills/rigors?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>21. Did s/he have convulsions or fits?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>22. Was s/he unconscious during the illness that led to death?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>23. Did s/he develop stiffness of the whole body?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>24. Did s/he have a stiff neck (demonstrate)?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p> <p>25A. Did s/he have diarrhoea (more frequent or more liquid stools)?</p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. Unknown <input type="checkbox"/></p>	

