Annex

Recording of Postpartum Family Planning Data

Instructions for completing the FP Service Record or FP Form 1 to include information on Postpartum Family Planning
(adapted from Family Planning Competency-Based Training: Basic Course Handbook)

SIDE A
Fill out or check the required information at the far right of the form:

Client number, date and time client was interviewed

Client name: last name, given name, date of birth, education, and occupation
Spouse name: last name, given name, date of birth, education, and occupation

Complete address of the client: number of the house, street, barangay, municipality, and province

Average monthly income in peso

Choose "yes" or "no" for the couple's plan for more children

Choose "new" or "continuing/current user" for type of acceptor

Number of living children

Previously used method

Reasons for practicing FP: completed the desired family size, economic, and others
Check among the list of FP method, the method accepted
Check if the FP method chosen was during postpartum period or interval

SIDE B
Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.

On the first column, record the date when the service was delivered to the client.
On the second column, record the method accepted/number of supplies given.
On the third column, record the following:

- Medical observations
- Complaints
- Services rendered, procedures/interventions done (lab, treatment)
- Reasons for stopping or changing the methods
- Laboratory results

On the fourth column, record the name of the provider with the corresponding signature.
On the fifth column, record the next service date or appointment date.

FAMILY PLANNING SERVICE RECORD

SIDE A

CLIENT NO.: _____ **TYPE OF ACCEPTOR:** ☐New to the program ☐Continuing User **PREVIOUSLY USED METHOD:** _____ **DATE/TIME** _____

NAME OF CLIENT: _____ ___/___/___ _____ _____ _____ _____
Last Name Given Name MI Date of Birth HIGHEST EDUC OCCUPATION NO. STREET BARANGAY MUNICIPALITY PROVINCE

NAME OF SPOUSE: _____ ___/___/___ _____ _____ **AVERAGE MONTHLY INCOME:** _____
Last Name Given Name MI Date of Birth HIGHEST EDUC OCCUPATION

NO. OF LIVING CHILDREN: _____ **PLAN MORE CHILDREN:** ☐Yes ☐No **REASON FOR PRACTICING FP:** _____

METHOD ACCEPTED: ☐COC ☐POP ☐Injectable ☐Condom ☐IUD ☐ BTL ☐NSV ☐LAM ☐SDM ☐BBT ☐BOM/CMM/STM ☐Implant **TIMING :** ☐Postpartum ☐Interval

MEDICAL HISTORY

HEENT
- ☐ Epilepsy/Convulsion/Seizure
- ☐ Severe headache/dizziness
- ☐ Visual disturbance/blurring of vision
- ☐ Yellowish conjunctivae
- ☐ Enlarged thyroid

CHEST/HEART
- ☐ Severe chest pain
- ☐ Shortness of breath and easy fatigability
- ☐ Breast/axillary mass
- ☐ Nipple discharge (specify if blood or pus)
- ☐ Systolic of 140 and above
- ☐ Diastolic of 90 and above
- ☐ Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases

ABDOMEN
- ☐ Mass in the abdomen
- ☐ History of gall bladder disease
- ☐ History of liver disease

GENITAL
- ☐ Mass in the uterus
- ☐ Vaginal discharge
- ☐ Intermenstrual bleeding
- ☐ Postcoital bleeding

EXTREMITIES
- ☐ Severe varicosities
- ☐ Swelling or severe pain in the legs not related to injuries

SKIN
- ☐ Yellowish skin

HISTORY OF ANY OF THE FOLLOWING
- ☐ Smoking
- ☐ Allergies
- ☐ Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)
- ☐ STI/HIV/AIDS/PIDS
- ☐ Bleeding tendencies (nose, gums, etc.)
- ☐ Anemia
- ☐ Diabetes

OBSTETRICAL HISTORY
- ☐ Number of pregnancies:
  ___Full term ___Premature
  ___Abortion ___Living Children
- ☐ Date of last delivery ____/____/____
- ☐ Type of last delivery _____
- ☐ Past menstrual period _____
- ☐ Last menstrual period _____
- ☐ Number of days menses
  ___Scanty ___Moderate ___Heavy
  ___Painful ___Regular
- ☐ Hydatidiform mole (within the last 12 months)
- ☐ Ectopic pregnancy

STI RISKS
- ☐ With history of multiple partners
- ☐ For Women:
- ☐ Unusual discharge from vagina
- ☐ Itching or sores in or around vagina
- ☐ Pain or burning sensation
- ☐ Treated for STIs in the past
- ☐ For Men:
- ☐ Pain or burning sensation
- ☐ Open sores anywhere in genital area
- ☐ Pus coming from penis
- ☐ Treated for STIs in the past

PHYSICAL EXAMINATION

Blood pressure: _____ mm/Hg
Weight _____ kg/lbs
Pulse rate _____ /min

CONJUNCTIVA
- ☐ Pale
- ☐ Yellowish

NECK
- ☐ Enlarged thyroid
- ☐ Enlarged lymph nodes

BREAST
- ☐ Mass
- ☐ Nipple discharge
- ☐ Skin-orange peel or dimpling
- ☐ Enlarged axillary lymph nodes

THORAX
- ☐ Abnormal heart sounds/cardiac rate
- ☐ Abnormal breath sounds/respiratory rate

ABDOMEN
- ☐ Enlarged liver
- ☐ Mass
- ☐ Varicosities

EXTREMITIES
- ☐ Edema
- ☐ Varicosities

PELVIC EXAMINATION

PERINEUM
- ☐ Scars
- ☐ Warts
- ☐ Reddish
- ☐ Laceration

VAGINA
- ☐ Congested
- ☐ Bartholin's cyst
- ☐ Warts
- ☐ Skene's gland discharge
- ☐ Rectocele
- ☐ Cystocele

CERVIX
- ☐ Congested
- ☐ Erosion
- ☐ Discharge
- ☐ Polyps/cysts
- ☐ Laceration

CONSISTENCY
- ☐ Firm
- ☐ Soft

UTERUS

Position
- ☐ Mid
- ☐ Anteflexed
- ☐ Retroflexed

Size
- ☐ Normal
- ☐ Small
- ☐ Large
- ☐ Mass

Uterine Depth: ____ cms.
(for intended IUD users)

ADNEXA
- ☐ Mass
- ☐ Tenderness

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)
- ☐ History of domestic violence or VAW
- ☐ Unpleasant relationships with partner
- ☐ Partner does not approve of the visit to FP clinic
- ☐ Partner disagrees to use FP

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs
☐ Others (specify: _____)

ACKNOWLEDGEMENT:
This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ _____
Client Signature Date

Reminder: Kindly refer to PHYSICIAN for any check (/) marks prior to provision of any method for further evaluation

SIDE B	FAMILY PLANNING SERVICE RECORD				
CLINET NUMBER ______ NAME OF CLIENT: ______ (Last Name, Given Name, MI) ______ __/__/__ Date of Birth **Education** ______ **Occupation** ______ **Address** ______ (No. Street *Barangay* Municipality Province	**DATE SERVICE GIVEN**	**METHOD TO BE USED/ SUPPLIES GIVEN** (cycles, pieces, etc.)	**REMARKS** • MEDICAL OBSERVATION • COMPLAINTS/ COMPLICATION • SERVICE RENDERED/ PROCEDURES/ INTERVENTIONS DONE (i.e. laboratory examination, treatment, referrals, etc.)	**NAME AND SIGNATURE OF PROVIDER**	**NEXT SERVICE DATE**