**Health Center Low Birth Weight (LBW) Baby (<2000gm) Registration Form (Delivery Room)**

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| **Identification** | **Delivery and Newborn status** | Remark |
| Serial No. | Name of mother | Zone | Kebele | Name of HDA (1-30) network leader | Delivery date **(DD/MM/YY)** and time **(00:00)** | Birth weight in grams | Referred to higher facility  **((DD/MM/YY)**  | Died Immediately After birth (**Y/N)** | Telephone #1 |
| MRN | Name of Husband | Woreda | Gote | Name of health facility referred | Cause of death | Telephone #2 |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
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**(9) Prematurity, Infection, Asphyxia, Cong. Mal, or others**

**Health Center LBW Register V 1.0**

**MNH services register Version 01, page 01**