राजस्थान सरकार

निदेशालय, चिकित्सा, स्वास्थ्य एवं परिवार कल्याण सेवायें, राज. जयपुर।



क्रमांक:27/COVID/2020/ 70 (

दिनांक: 24-6-2020

दिशा-निर्देश

विषय :-संस्थागत कोरोना संक्रमित मृत्यु की समीक्षा आयोजित करने के क्रम में विस्तृत दिशा-निर्देश।

विश्व स्वास्थ्य संगठन तथा संयुक्त राष्ट्र द्वारा कोरोना वायरस (कोविड—19) संक्रमण को Pandemic घोषित करने तथा कोरोना वायरस (कोविड—19) संक्रमण से बचाव, रोकथाम हेतु तथा आमजन को आवश्यक चिकित्सा सुविधा उपलब्ध कराने के संबंध मे व्यापक लोकहित मे राज्य सरकार द्वारा सभी सम्भव प्रयास किये जा रहे है। इसी क्रम मे चिकित्सा संस्थानों मे कोरोना संक्रमित मृत्यु की समीक्षा हेतु मुख्य कार्य निम्नानुसार किया जाना है:—

- 1. समीक्षा समीति का गठन:— समीक्षा हेतु संबंधित संस्थान कोविड़ नोडल अधिकारी अथवा Infection control committee नोडल अधिकारी द्वारा विशेषज्ञ समीति का गठन कर फार्म—4 मे प्रविष्टि करे।
- 2. समीति **फार्म संख्या—4** भर कर अपनी रिपोर्ट उसी दिवस में कोविड़ नोडल अधिकारी के माध्यम से **डिप्टी** सीएमएचओं (स्वास्थ्य) को प्रेषित करायेगे।
- 3. बैठक की जानकारी गोपनीय रखी जावेगी व स्वास्थ्य सेवाओं की उपलब्धता के सुदृढीकरण हेतु उपयोग में लायी जावगी।
- 4. उक्त विश्लेषण उपरान्त उप मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी (स्वास्थ्य) लाईल लिस्टिंग संधारित कर फार्म–4 को राज्य स्तर को प्रेषित करेगे।
- 5. डिप्टी सीएमएचओ (स्वास्थ्य) उक्त सूचना का विश्लेषण सीएमएचओ की अध्यक्षता मे जिला स्तरीय समीति में करेगे जिसमें संबंधित संस्था प्रभारी, Epidemiologist व जिला कार्यक्रम प्रबंधक सिम्मिलित होगे व कोरोना संक्रमित मातृ शिशु मृत्यु स्थिति मे आरसीएचओ भी उक्त बैठक में भाग लेगे।
- 6. उक्त विश्लेषण उपरान्त जिला मजिस्ट्रेट महोदय को अवगत करा कर रिपोर्ट राज्य स्तर पर फार्म- 4 में राज्य नोडल अधिकारी-आईडीएसपी को प्रेषित की जावेगी।

उक्तानुसार समस्त कार्य आगामी 7 दिवस में पूर्ण कर अधोहस्ताक्षरकर्ता को ईमेल आईडी rajasthan_idsp@yahoo.co.in व no_camp.nrhm@yahoo.com पर अवगत कराये व आवश्यकता अनुसार सहयोग हेतु राज्य मुख्यालय आईडीएसपी अनुभाग, एनएचएम से सम्पर्क कर सकते हैं।

फार्म-4

संस्थागत कोविड़ मृत्यु इक्जाई सूचना

अतिक्ति मुख्य सचिव, चिकित्सा एवं स्वास्थ्य विभाग, राजस्थान सरकार, जयपुर।

प्रतिलिपि निम्न को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है:--

1. विशिष्ठ सहायक, माननीय चिकित्सा मंत्री महोदय।

निजी सचिव, अतिरिक्त मुख्य सचिव, चिकित्सा एंव स्वास्थ्य विभाग।

निजी सचिव, शासन सचिव, चिकित्सा शिक्षा विभाग, जयपुर।

- 4. निजी सचिव, विशिष्ट शासन सचिव, चि0 स्वा0 एवं प००० विभाग एवं मिशन निदेशक, एनएचएम।
- समस्त निदेशक, चिकित्सा एवं स्वास्थ्य सेवाऐं, राज. जयपुर।
- राज्य नोडल अधिकारी, आईडीएसपी / कोविड़ मृत्यु समीक्षा।
- संयुक्त निदेशक, चिकित्सा एवं स्वास्थ्य सेवाऐं, जोन जयपुर।
- प्रिसिंपल एवं कंट्रोलर / मेडिकल सुपिरटेन्डेन्ट समस्त मेडिकल कॉलेज, संलग्न अस्पताल।
- मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, समस्त जिले।
- 10. प्रमुख चिकित्सा अधिकारी, जिला अस्पताल।
- 11. उप मुख्य विकित्सा एवं स्वास्थ्य अधिकारी (स्वास्थ्य), समस्त जिले।
- 12. समस्त प्रमुख चिकित्सा अधिकारी, जिला चिकित्सालय, जयपुर।
- 13. सर्वर रूम।
- 14. रक्षित पत्रावली।

(नरेश कुमार ठकराल) मिशन निदेशक, एनएचएम एवं विशिष्ट शासन सचिव चिकि. स्वा. एवं पं. क

Form 4 Confidential

Facility Based COVID-19 Death Summary Form

新華 知山上東華

NOTE:

- This form must be filled for all Institutional COVID Deaths.
- Mark with $\sqrt{\text{wherever applicable.}}$

C] Brought dead-----

- For Date use Day/Month/Year format. For time use 24 hours clock format.
- Complete within 24 hrs.
- Make 2 photocopies & send original to MRD, a copy to DNO/Dy CMHO(H), and one retained with nodal Officer for further action.

(Performa to be filled up for the COVID-19 confirmed patients who have died) 1. Name of the referral hospital with address: 2. Duration of stay in referral hospital: 3. Reported by Medical Unit: CR no 4. Patient Identification Data: b) Date of Birth (dd/mm/yy) - -/- -/--- Age (in yrs): --Male \square Female 🔲 c) Sex If Female, was the patient pregnant? Yes [(weeks pregnant) ____ No [Unknown [d) Residential status: Urban Rural, e) specify address with contact telephone no. (mobile preferred) of family member_____ 5. History of contact with COVID-19 positive/ Foreign travel/ Paramedical staff/ Clinician/ Suspect COVID-19 in community/ attended a large congregation a) Clinical Data (Please tick one or more than one symptoms/ailments the patient had) B] Symptomatic Al Asymptomatic -----

b) Sign	ns and symptoms with date of ons	t (dd/mm/yy)	://	
 Mile Cou Fati Bre Sor Vo 	igh	>	High grade fever Fall in Blood Pressure Sputum with blood Loss of smell Loss of taste Any other, specify	
6. Did the pa	atient have any high risk illness	predisposing	condition	
i) ii)	Age >65 years- ☐ Yes ☐ No Diabetes mellitus ☐ Yes ☐ Con	rolled 🗆 Un	controlled 🗌 No 🗀	Unknown
iii)	Chronic Lung disease (specify w			
iv)	Hypertension & Coronary artery			
v)	HIV +ve only Yes □ N			
vi)	AIDS Yes □ No	☐ Unknov	vn 🗌	
vii)	Chronic Liver disease (specify	ith duration) _		
viii)	Chronic Kidney disease (speci	y with duration	n)	
ix)	Cancer (specify with duration)			
x)	History of Cerebrovascular Acc	dent		_
xi)	Cortisone therapy + Immuno suppressive Therapy	Yes [□ No □ Unknow	n 🗌
xii)	Incidental/ Accidental Disorder Anaesthetic complications, Any other (specify with durations)			

a)) General te	ete.						
a)				Ferritin				
	DLC		•		itonin			
	CRP				er		_	
	LDH							
	Any o	ther		r -				
b)			any of the foll	lowing tests	s?			
-,			If ye			Abnorma	l □ Unknov	vn
	Cł	est CT sc	an If ye	s. 🗀 🗎			l 🖂 Unknov	
	_		,	-, L	_		. 🖰	
c)) If chest x-	ray or ch	ests CT scan re	sult abnorn	nal:			
	Was there	evidence	of pneumonia?	?				
		Yes	□ No	T	Jnknown []		
ď)) SARS-Co	V-2 testin	g:					
	Date of co	ollection o	f sample:// of First result:	//				
	Name of t	he lab wh	ich conducted	test:				
	Result: Da	aywise	•					
		•						
	Day 0	Day 3	Day 6	Day 9	Day	Day	Day	Day
	Day 0	Day 3	Day 6	Day 9	Day	Day	Day	Day
Ти			Day 6	Day 9	Day	Day	Day	Day
	eatment det	ails						
a	eatment det a) Previous 1	ails	history				Day	
a	eatment det a) Previous 1	ails						
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System	Exar	nple	Y	N	Not knowr
Personal/	delay in seeking help				
family	refusal of treatment or admission				****
	refusal of admission in				
logistical Problems	lack of transport from l				
	lack of transport betwe facilities	en health care			
	lack of assured referra	l system			
facilities	lack of facilities, equip	oment or			
	lack of blood/ blood p	roducts			,
	lack of Ot availability	y			
Health	lack of human resourc	es lack			
personnel problems	of anesthetist				
	lack of expertise, train	ing or education			
stay and the	death of the patient)		-		
	oy the MO on duty	nodal Officer o		ospital	:
Form filled Name & Sig Designation	•	nodal Officer of Name& Signar	ture	-	•

Stamp & Date: