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| **SOCIO-DEMOGRAPHIC INFORMATION** | | |
| 1.Client name (first, middle, last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 2.Client Number: |
| 3. Birth date (DD/MM/YYYY)  / \_/ | 4.Date today (DD/MM/YYYY)  / \_/ | 5.Infant’s age today (days) |
| 6. Facility Name (Name in full): |  | |
| 7. Sub-County of residence: |  | |
| 8. Place of birth: | □Home □Health facility □Other (specify): | |
| 9. Referred from *(tick one):* | □Self-referral □ANC □Maternity □Delivery □Pediatric ward  □Pediatric outpatient □Other (specify): | |
| 10. Parent/guardian name: *(tick all that apply)* | □Mother: | |
| □Father: | |
| □Guardian: | |
| 11. Telephone number: |  | |
| **CONSENT STATUS** | | |
| 12. Written informed consent  obtained? *(tick one)* | □YES □NO *(MC should not be performed)* | |
| 13. Written Consent obtained from  *(mandatory)* | □Mother □Father □Guardian | |
| **MEDICAL HISTORY** | | |
| 14. Mother’s HIV status :  *(If unknown, offer testing or refer mother and infant as appropriate. Document referrals on final page. Do not delay circumcision due to mother’s HIV + or unknown status).* | HIV test date (DD/MM/YYYY):  Result (tick one): □ Negative □New positive  □Unknown □Known positive; in care  *Negative HIV test must be documented. If obtained more than 3 months ago, repeat as per national guidelines.* | |
| 15. Vitamin K administered? (*tick one*)  (*Do not circumcise infant <8 days*  *without 1 dose Vitamin K today or earlier)* | □YES (Administered today)  □YES (Administered at birth)  □NO | |
| 16. Has the baby passed urine? (*tick one*)  (*Do not circumcise if urination not reported)* | □YES □NO | |
| 17. Mother has documentation of or reports: two prior TT doses of which at least one was this pregnancy, **OR** three prior TT doses with none this pregnancy | □YES □NO | |
| ***Note****: If any answer below is yes, do not circumcise* | | |
| 18. Family or infant history of  bleeding disorder *(excessive bleeding with surgery, minor injury, tooth extractions)* | □YES □NO | |
| 19. Infant history of convulsion | □YES □NO | |
| 20. Other serious medical  condition *(a previous health issue is not a problem if infant is well)* | □YES □NO | |

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| ***Note:*** *If any answer below is yes, do not circumcise and refer as appropriate and document referral on final page* | | | |
| **PHYSICAL EXAM/ELIGIBILITY** | | **Check one** | |
| **Yes** | **No** |  |
| 22. Current weight\_\_\_\_\_kg Too low for age per job aid? (WHO child growth standards) | |  |  |
| 23. Less than 37 weeks corrected gestational age *(if unknown, use other criteria)* | |  |  |
| 24. Infant <12 hours or > 60 days old | |  |  |
| 25. Any vital signsoutside normal  rangeswhen baby is calm | Temperature (C): (36.5o – 37.5oC) |  |  |
| Respiratory rate (b/min): (30-60 b/min) |  |  |
| Heart rate (bpm): \_\_\_\_\_\_ (120 – 160 bpm) |  |  |
| 26. Unwell-appearing or poorly responsive | |  |  |
| 27. Medical contraindication *(specify):*  *(includes jaundice or icterus, loud heart murmur or other abnormal heart sounds, petechiae or multiple bruises, crackles or other abnormal lung sounds)* | |  |  |
| 28. Anatomic abnormality *(specify):*  *(includes penile torsion, median raphe not midline, hypospadias or epispadias, abnormal urethra, buried penis, penile length < 1 cm, penile scrotal web, hydrocele, dorsal hood, abnormal scrotal ruggae, foreskin abnormality, other genital abnormality)* | |  |  |

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| **EIMC PROCEDURE** | | |
| 29. Date of procedure: | | |
| 30. Start Time: | Procedure started at: \_: (in 24 hrs) | |
| 31. End Time: | Procedure ended at: : (in 24 hrs) | |
| 32. Pre-operative medication: | Medication: □ Paracetamol (give 15mg/Kg body weight) □ other: \_\_\_\_\_\_\_\_  Dose:  *(refer to job aid for dosage)* | |
| 33. Anesthesia: | Concentration and dose *(tick one and fill in dose):*  □Lidocaine 1% mL (maximum safe dose 0.3mL/kg)  □Lidocaine 2% mL (maximum safe dose 0.15mL/kg) diluted to total volume of 1 mL using sterile water for injection | |
| 34. Procedure | Technique *(tick one*):  □ dorsal penile nerve block □ Other (specify\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Device *(tick one):*  □ Mogen Clamp □ Other (specify)\_ | |
| 35. Intraoperative Adverse  Events | Intraoperative adverse events: □Yes □ No | |
|  | Adverse Event Type: | |
|  | Adverse Event Severity:  □Mild □Moderate □Severe  *(document management of all AEs and referrals on the clinical notes page)* | |
| 36. Name of Surgeon: Last Name Other Names  37. Cadre: □MO □CO □NO 38. Surgeon Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 39. Name of Assistant Surgeon: Last Name Other Names\_  40. Cadre: □MO □CO □NO 41. Assistant Surgeon Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **POST-OPERATIVE FOLLOW UP** | | |
| 42. Date of Review: | |  |
| 43. Type of Follow-Up | | □ Day 3 □ Other (specify) |
| 44. Vital Signs: | | Temp. Heart rate bpm Respiratory rate: b/min |
| 46. Infant well-being | | Has infant had poor feeding, fussiness or diminished urination? □YES □NO |
| 45. Adverse Event reported: | | Adverse event or abnormality in wound appearance? □YES □NO |
| Adverse Event Type (enter AE Code):  *(refer to the AE description form)* |
| Adverse Event Severity:  □Mild □Moderate □Severe  *(Document management of all AEs and referrals on the clinical notes page)* |
| 46. Name of Reviewing Officer: Last Name Other Names\_  47.Cadre: □M.O. □C.O. □N.O. Reviewing Officer Signature:  48. Return visit needed? □NO □YES, if yes when? Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **REFERRALS** | |
| 49. Referral Date: (DD/MM/YYYY) / / | |
| 50. Referred to *(tick all that*  *apply):*  *(Infant should be referred when appropriate without regard to whether he is circumcised this day.)* | □PNC  □Infant six weeks & above for dried blood spot for HIV testing  □HIV Care & Treatment  □Pediatric outpatient or ward for EIMC complication  □Pediatric outpatient or ward for non-EIMC issue *(specify):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Other *(specify):* |
| 51. Referral facility name: |  |

**52: Clinical notes:**

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