Ministry of Health & Family Welfare
Government of India

Rashtriya Bal Swasthya Karyakram (RBSK)
Screening and Referral Tool for Children (6 - 18 years)

Preliminary Particulars

District/Block	**Mobile Health Team ID**	**Name of School**	**School ID / DISE code**
Name of Child:	***Age (in yrs, months)**	**Gender (M/F)** M ☐ F ☐	**Class / Section**
MCTS No. (16 Digit)			**AADHAAR No.**
Unique ID (16 Digit)			
Name of Father/Guardian	**Name of Mother**	**Contact Number**	**Name of Teacher** / **Contact number**

Weight (in kg)	**Height (in cm.)**	**Body Mass Index: Calculate (Weight in kg/Height^2 (in m^2)**	**BMI Classification - Tick as appropriate** (N: No referral / U: Underweight / O: Obese		
			N ☐	**U ≤- 3SD** ☐	**O >+2SD** ☐

Blood Pressure (mmHg) (Systolic / Diastolic) **	Normal ☐	Prehypertension ☐	Stage 1 HTN ☐	Stage 2 HTN ☐	**Acuity of Vision (Snellen's Chart)**	
					Left Eye _/ 6ft	**Right Eye** _/ 6 ft.

****Blood Pressure (in mmHg). Use table in Job aids** for a given age (i.e. completed yrs. at mid–year), use the closest height (in cm) in the table and look right below the height column for **the SBP** (Systolic Blood Pressure) & Classify: Normal, Prehypertension, Stage 1 Hypertension (HTN) and Stage 2 HTN. (SBP>120 mm of Hg is also Prehypertension)

A. Defects at Birth, If YES Refer

A1	Any visible Defect at Birth in the Child viz Cleft Lip/Palate/Club foot/Down's syndrome/ Cataract etc.	☐

B. Deficiencies, If YES Refer

B1	**Severe Thinning (SAM like)** : Body Mass Index: weight /height ratio as per BMI chart ≤ -3 SD refer and counsel for moderate thinning : <- 2SD to >-3SD	☐	**B5**	**Vitamin D Deficiency** – Look for Wrist Widening/Bowing of legs	☐
B2	**Bilateral pitting oedema esp. at feet (check for acute malnutrition or other causes)**	☐	**B6**	**Goitre – look** Any swelling in the neck region	☐
B3	**Severe anemia** – Look for severe palmar pallor	☐	**B7**	**Obesity:** Body Mass Index: weight /height ratio as per BMI chart > + 2 SD	☐
B4	**Vitamin A Deficiency** – Look for night blindness/look for Bitot's spot (white patches on sclera	☐	**B8**	**Vitamin B complex Def. :** Angular stomatitis , cheilosis , magenta/ fissured/ Raw tongue ;corneal vascularization, malar & supra orbital pigmentation	☐

C. Diseases, If YES Refer N.B. these are suspected but not confirmed

C1	**Convulsive Disorders** – Did the child ever have had spells of unconsciousness and fits?	☐	**C4**	**Skin Condition other than leprosy** - Does the child have skin lesion with : a) itching (esp. at night); b) scaly lesion; c) painful to touch; d) changing periodically with season; e) preceded by trauma or Infection?. Look esp. for round or oval lesion with scales or pustules in finger webs	☐
C2	**Otitis Media** - Did the child have more than 3 episodes of ear discharge in last 1 year? Look for Active discharge from ear. Assess Hearing also.	☐			
C3	**Dental Condition** - Look for white demineralized/ brown tooth, Discoloration, cavitation, Swollen/bleeding/red gums, Visible Plaque/stains	☐	**C5**	Asthma or Reactive airway disease: More than 3 Episodes of increased shortness of breath and difficult breathing and wheezing in the past 6 months	☐
			C6	**Rheumatic Heart Disease** – Auscultate for Murmur	☐
C7	**Childhood Leprosy Disease** (Hansen's disease)		**C8**	Childhood tuberculosis both pulmonary and extra- pulmonary	

C7	**CHILDHOOD LEPROSY DISEASE:** LOOK, ASK & PERFORM **for a)Skin lesion; b) Peripheral Nerve involvement; or c) Contractures & Deformity ? If any of these below is positive, refer for Leprosy Disease**						
C7.1	Look for Hypo-pigmented or reddish skin lesion with Definite Sensory Deficit. Skin Lesion should not be painful, not changing periodically with seasons i.e. appearing or disappearing, not itchy, not shedding scales, not preceded by any inflammation or any local Injection and is not dark red, or completely depigmented. if yes: tick and Refer						☐
C7.1.1	**If C7.1 is yes,** Number of lesions present?		**C7.1.2**	**If C7.1 is yes, T**ype of skin lesion**; tick accordingly**			
	1 to 5 lesions	☐		Patchy ☐	Plaque ☐	Nodular ☐	Diffuse infiltration ☐
	> 5 lesions	☐					
C7.2	**If Involvement of the peripheral nerve present** then tick as appropriate nerve						☐
	Behind the Ear (Greater Auricular Nerve)	☐		Definite thickening with or without tenderness			☐
	Around Elbow (Ulnar nerve)	☐		Loss of sensation			☐
	Wrist (Radial cutaneous nerve)	☐		Weakness of the muscles of the hands			☐
	Knee (Peroneal Nerve)	☐		Weakness of the muscles of the feet			☐
	Ankle joints (Posterior tibial nerve)	☐		Weakness of the muscles of the eyes			☐
C7.3	**Look** for **Contractures and deformity:** only if presented after infancy and with no history of Meningitis, Encephalitis or Trauma in the past, **if yes, Note location, Mark as appropriate**						☐
	Right Hand	Left Hand	Right Feet	**Left Feet**	**Eyes**	**Face**	
	☐	☐	☐	☐	☐	☐	
	If any of the above is positive i.e Skin lesion (C7.1)/Nerve involement (C7.2)/Contracture (C7.3) refer for Leprosy						☐

C8	CHILDHOOD TUBERCULAR DISEASE: LOOK, ASK & PERFORM	
8.1	Does the child have cough for more than 14 days not responding to conventional antibiotics (Amoxycillin, Amoxiclav, cotrimoxazole or cephalosporins) and/or bronchodilators? If Yes Tick √	☐
8.2	Does the child have Persistent documented fever (axillary temperature above 37.5 °C or 99.5^{0}F) for more than 2 weeks after common cases such as typhoid, malaria or pneumonia or viral infection have been excluded? If Yes Tick √	☐
8.3	Does the child present with marked reduction in the playfulness/ daily activity /appetite/not interacting with surroundings or parents leading to a caregiver's concern for > 7 days? If Yes Tick √	☐
8.4	Does the child present with Recent headache and irritability and /or has recent altered behavior for > 5 days? If Yes Tick √	☐
8.5	Does the child have documented weight loss of more than 5 % in reference to the highest recorded weight during the past 6 months, esp. not responding to de-worming and micronutrient supplementation or SAM not responding to nutritional support? if Yes Tick √	☐
8.6	Does the child have history of Close contact with a known case of TB such as parents, siblings, close relatives, caregivers, neighbors and teachers?. If Yes Tick √	☐
8.7	Does the child have a history of having measles, Varicella in the previous 3 months or is on steroid or on chemotherapy for more than 1 month? If Yes Tick √	☐

8.8.	Does the child present with dull aching abdominal pain with abdominal swelling or painless abdominal mass?	☐
	Hepatomegaly Splenomegaly ☐ / Abdominal mass ☐ / Abdominal fluid ☐ / Pain abdomen ☐	

8.9	Does the child have gradually increasing painless swelling of one or more lymph nodes that has not responded to a course of antibiotics after 2 weeks? (Enlarged only: when in the neck > 1.5 cm and axilla / Inguinal > 2 cm If Yes Tick)	☐
	Single discrete node ☐ / Multiple matted nodes ☐ / Non-tender & Painless ☐ / Discharging sinus ☐	

8.10	Does the child present with a constant back pain & stiffness ranging from mild dull aching to severe disabling swelling &/or recent Spinal deformity	☐
	A cold abscess ☐ / Typical night cries ☐ / localized kyphotic deformity ☐ / spine is stiff and painful on movement ☐	

8.11		
	a. Altered level of consciousness	☐
	b. Convulsions occurring without fever	☐
	c. History of Vomiting without diarrhea	☐
	d. Check for: recent Focal neurological deficit and or abnormal movements within the past 1 month.	☐
	e. Check for recent headache and irritability and /or has recent altered behavior for > 7 days but within a month ? If Yes Tick √	☐
	f. Check for: Recent Cranial nerve palsy e.g. sudden squint or sudden asymmetry of face	☐
	g. Neck stiffness/ Neck rigidity	☐
	Any one is present: consider Neuro TB	☐

8.12	Respiratory distress i.e. difficulty in breathing or Persistent cough for > 2 weeks			☐
	Increased respiratory rate* ☐	Persisting cough (>2 weeks) ☐	difficult-to-treat pneumonia ☐	

8.13	Does the child present with recent onset of limping or painful swelling of a joint esp night cry? If yes Tick	☐

C8		
	a) Tick if any one of the following symptoms is positive or Yes : from 8.1 to 8.7 in Pulmonary TB Box	☐
	b) Presence of any positive symtom from either 8.8 (abdominal TB) or 8.9 (T.B. Lymph nodes) or 8. 10(T.B. spine) or 8.11 (CNS TB) or 8.13 (Bone T.B) ; tick positive in Extra Pulmonary TB Box	☐
	c) Presence of any positive symtom from 8.12 ; tick positive in Pulmonary TB Box	

*Respiratory rate: If more than 30 breaths per minute

** Conventional antibiotics: Amoxycillin, Amoxiclav, co-trimoxazole or cephalosporins.

Please note that these medicines are used for Drug Resistant Tuberculosis like Fluoroquinolones like Levofloxacin (Lfx), Moxifloxacin (Mfx); Aminoglycosides: Amikacin (Am); Kanamycin (Km);

Remember that signs and symtoms suggestive of TB is non specific

D. Developmental delay including disability, If YES Refer

D1	Does the child have difficulty in seeing, either during day or night? (without spectacles) **(V)**	☐	D5	Compared to his/her classmates, does the child find it difficult to read or write or to do simple calculations? **(LD)**	☐
D2	Compared with other children of his/her age, did the child have any delay in walking? **(GM)**	☐	D6	Does the child have any difficulty in speaking as compared to other children of his/her age? **(Sp)**	☐
D3	Does the child have stiffness or floppiness and/or reduced strength in his/her arms or legs? **(GM, NMI)**	☐	D7	Does the child have difficulty in hearing? (without hearing aid) **(H)**	☐
D4	From birth till date, has the child ever had fits, or became rigid, or had sudden jerks or spasms of arms, legs or whole body? Refer if the fits are uncontrolled **(Convulsive disorder)**	☐	D8	Compared with other children of his / her age, does the child have difficulty in learning new things? (LD/C)	☐
			D9	As compared to children of his/her age, does the child have difficulty in sustaining attention on activities at school, home or play? **(ADHD)**	☐

E. Adolescent Specific Questionnaire (10-18 years) Refer as per Instructions

NOTE: Following questions to be asked only after audio visual privacy is ensured

E1	Do you always find it difficult to handle things in your life that has resulted from changes occurring in your body? **(If Y, Refer)**	☐	E5	Do you have your periods every month (i.e.28 ± 7 days)? **(If N, Refer)**	☐
E2	Are you able to say "NO" and leave the place when your friends pressurize you to smoke or drink with them? **(If N, Refer)**	☐	E6	Do you experience any pain or burning sensation while urinating? **(If Y, Refer)**	☐
E3	Do you feel unduly tired early in the morning or you feel depressed most of the time? **(If Y, Refer)**	☐	E7	Do you have any discharge/ foul smelling discharge from the genitor-urinary area? **(If Y, Refer)** **In case of foul discharge with past history or contact of TB: please refer for TB confirmatory evaluation**	☐
E4	**In case of females-** Have your menstrual cycles, started yet? **(If not started by 16 years, Refer)** **In case of infrequent or light mensuration with past history or contact of TB : please refer for TB confirmatory evaluation**	☐	E8	Do you feel extreme pain during menstruation so much so that it stops you from doing routine activities/ attend schools? **(If Y, Refer)**	☐

Preliminary Findings (Tick as Applicable)

Defects at Birth		√	Deficiencies		√	Diseases		√	Developmental delay including disability		√	Adolescent Health concerns		√
CODE	Findings		CODE	Findings		CODE	Findings		CODE	Findings		CODE	Findings	
1	Neural Tube Defect	☐	10	Anemia	☐	15	Skin Conditions Not Leprosy	☐	21	Vision Impairment	☐	31	Growing up concerns	☐
2	Down's Syndrome	☐	11	Vitamin A Def.	☐	16	Otitis Media	☐	22	Hearing Impairment	☐	32	Substance abuse	☐
3	Cleft Lip & Palate	☐	12	Vitamin D Def. (Rickets)	☐	17	Rheumatic Heart Disease	☐	23	Neuro-motor Impairment	☐	33	Feel depressed	☐
4	Talipes (club foot)	☐	13	SAM/ Stunting	☐	18	Reactive Airway Disease	☐	24	Motor delay	☐	34	Delay in menstrual cycles	☐
5	Developmental Dysplasia of Hip	☐	14	Goiter	☐	19	Dental Conditions	☐	25	Cognitive Delay	☐	35	Irregular periods	☐
6	Congenital Cataract	☐	44.	**Vitamin B complex def.**	☐	20	Convulsive Disorders	☐	26	Speech and Language Delay	☐	36	Pain or burning sensation while urinating	☐
7	Congenital Deafness	☐	**30 Others (Specify)**			39	Childhood Leprosy Disease	☐	27	Behavioural Disorder (Autism)	☐	37	Discharge / foul smelling discharge from the genitourinary area	☐
8	Congenital Heart Disease	☐				40	Childhood Tuberculosis	☐	28	Learning Disorder	☐			
9	Retinopathy of prematurity (only at DH)	☐				40.1	Childhood Tuberculosis (Extra Pulmonary)	☐	29	Attention Deficit Hyperactivity Disorder	☐	38	Pain during menstruation	☐

Please √ as appropriate	Defects at Birth	Deficiency	Disease	Developmental Delay	Adolescent Health Concern	Others
	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
If yes, Refer to	DH/DEIC	PHC/CHC	PHC/CHC/DH	DEIC	CHC/AFHC	PHC/CHC/DH
Referral	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
Name of referral facility						

Name and Sign of Doctor, MHT	**Sign of Teacher**	**Date of Visit**
Data entered in Register - Yes /No	**Data entered in register by Name and Sign**	

**In case the referral has to be made for more than 1D especially involving the DEIC, the child must be referred to DEIC first.*