Opening Date:	2020-11-09
Closing Date:	2020-11-16
Closing Time:	11:00

INSTITUTION DETAILS

Institution Name:	King Edward VIII hospital
Province:	KwaZulu-Natal
Department or Entity:	Department of Health
Division or section:	Central Supply Chain Management
Place where goods / services is required	Ward 01
Date Submitted	2020-11-02

ITEM CATEGORY AND DETAILS

Quotation Number:	ZNQ: KEH553/20KZN
Item Category:	Goods
Item Description:	Supply and print 8-page neonatal records booklets and Nursing assessment admission and screening booklets, as per attached samples, Supplier awarded the order must be able to supply sample for approval before supplying the complete order.
Quantity (if supplies)	6000 Booklets of each

COMPULSORY BRIEFING SESSION / SITE VISIT

Select Type:	Not Applicable
Date :	
Time:	
Venue:	

QUOTES CAN BE COLLECTED FROM:	Quote attached to the advert.
QUOTES SHOULD BE DELIVERED TO:	King Edward Hospital, deposit in the tender box, situated in the admin block, off Sydney Road, Congella, 4013 (Please do not e-mail quotes).

ENQUIRIES REGARDING THE ADVERT MAY BE DIRECTED TO:

Name:	Louise Steyn
Email:	Louise.Steyn@kznhealth.gov.za (please do not e-mail completed quotes).
Contact Number:	031-3603448
~~Finance~~ Manager Name:	Mrs. Maphumulo
~~Finance~~ Manager Signature:	

STANDARD QUOTE DOCUMENTATION SUPPLY CHAIN MANAGEMENT OVER R30 000.00

YOU ARE HEREBY INVITED TO QUOTE FOR REQUIREMENTS AT: KING EDWARD HOSPITAL

DATE ADVERTISED: 9-11-2020 CLOSING DATE: 16-11-2020 CLOSING TIME: 11:00

FACSIMILE NUMBER: 031-2056722 E-MAIL ADDRESS: Louise.Steyn@kznhealth.gov.za

PHYSICAL ADDRESS: KING EDWARD HOSPITAL, GATE 2 FRANCOIS ROAD, CONGELLA, 4013

ZNQ NUMBER: KEH553/20KZN

DESCRIPTION: .....

CONTRACT PERIOD..... (*if applicable*) VALIDITY PERIOD 60 Days SARS PIN.....

CENTRAL SUPPLIER DATABASE REGISTRATION (CSD) NO.

UNIQUE REGISTRATION REFERENCE

DEPOSITED IN THE QUOTE BOX SITUATED AT *(STREET ADDRESS)*

.....

.....

Bidders should ensure that quotes are delivered timeously to the correct address. If the quote is late, it will not be accepted for consideration.

The quote box is open from 08:00 to 15:30.

ALL QUOTES MUST BE SUBMITTED ON THE OFFICIAL FORMS – (NOT TO BE RE-TYPED)

THIS QUOTE IS SUBJECT TO THE PREFERENTIAL PROCUREMENT POLICY FRAMEWORK ACT AND THE PREFERENTIAL PROCUREMENT REGULATIONS, 2011, THE GENERAL CONDITIONS OF CONTRACT (GCC) AND, IF APPLICABLE, ANY OTHER SPECIAL CONDITIONS OF CONTRACT.

THE FOLLOWING PARTICULARS MUST BE FURNISHED
(FAILURE TO DO SO WILL RESULT IN YOUR QUOTE BEING DISQUALIFIED)

NAME OF BIDDER .....

POSTAL ADDRESS .....

STREET ADDRESS .....

TELEPHONE NUMBER CODE.....NUMBER..... FACSIMILE NUMBER CODE .....NUMBER.....

CELLPHONE NUMBER .....

E-MAIL ADDRESS .....

VAT REGISTRATION NUMBER (If VAT vendor) .....

HAS A B-BBEE STATUS LEVEL VERIFICATION CERTIFICATE BEEN SUBMITTED? (SBD 6.1) YES NO

[A B-BBEE STATUS LEVEL VERIFICATION CERTIFICATE/SWORN AFFIDAVIT (FOR EMEs& QSEs) MUST BE SUBMITTED IN ORDER TO QUALIFY FOR PREFERENCE POINTS FOR B-BBEE]

OFFICIAL PRICE PAGE FOR QUOTATIONS ZNQ NUMBER: KEH553/20KZN

DESCRIPTION: .....

SIGNATURE OF BIDDER ..... DATE.....
[By signing this document I hereby agree to all terms and conditions]

CAPACITY UNDER WHICH THIS QUOTE IS SIGNED.....

Item No	Quantity	Description	Brand & model	Country of manufacture	Price	
					R	c
	Booklets	Supply and print of				
1.	6000	neonatal records, as per sample				
		Colour of paper white				
		Size of pager A4 Thickness of paper +- 100grams				
		Colour of printing black and colour,				
		Dept. of Health logo must be included & in colour				
		Printing in 8 page booklet, back to back				
		Binding on the left hand size with 2				
		staples of booklet				
		Packed 1000 booklets per box				
	Booklets					
2.	6000	Supply and print of Nursing, assessment,				
		admission and screening booklets, as per sample				
		Colour of paper, white				
		Colour of printing black, with the Dept. of				
		Health logo in colour.				
		Printing back to back				
		Size of paper A3, folded in size A4, binding				
		Printing in a 11-page A4 booklet				
		in the middle with 2 staples of the booklet				
		Packed 1000 booklets per box				
		Supplier awarded the tender, must be able to				
		supply sample for approval, before supplying				
		the order				
		Please supply the following with quote				
		Tax clearance certificate, BBBEE certificate,				
VALUE ADDED TAX @ 15% (Only if VAT Vendor)						
TOTAL QUOTATION PRICE (VALIDITY PERIOD 60 Days)						

Does This Offer Comply With The Specification?		Does The Article Conform To The S.A.N.S. / S.A.B.S. Specification?	
Is The Price Firm?		State Delivery Period E.G. *E.G. 1day, 1week*	

Enquiries regarding the quote may be directed to: Contact Person: Louise.....Tel:031-3603448 E-Mail Address: Louise.Steyn@kznhealth.gov.za	**Enquiries regarding technical information may be directed to:** Contact Person: .....Tel:.....

DECLARATION OF INTEREST

1. Any legal person, including persons employed by the state[1], or persons having a kinship with persons employed by the state, including a blood relationship, may make an offer or offers in terms of this invitation to quote (includes a price quotation, advertised competitive quote, limited quote or proposal). In view of possible allegations of favouritism, should the resulting quote, or part thereof, be awarded to persons employed by the state, or to persons connected with or related to them, it is required that the bidder or his/her authorised representative declare his/her position in relation to the evaluating/adjudicating authority where-
   - the bidder is employed by the state; and/or
   - the legal person on whose behalf the bidding document is signed, has a relationship with persons/a person who are/is involved in the evaluation and or adjudication of the quote(s), or where it is known that such a relationship exists between the person or persons for or on whose behalf the declarant acts and persons who are involved with the evaluation and or adjudication of the quote.
2. In order to give effect to the above, the following questionnaire must be completed and submitted with the quote.

2.1. Full Name of bidder/representative.....
2.2. Identity Number: .....
2.3. Position occupied in the Company (director, trustee, shareholder[2]):.....
2.4. Company Registration Number: .....
2.5. Tax Reference Number: .....
2.6. VAT Registration Number: .....

2.7. The names of all directors / trustees / shareholders / members, their individual identity numbers, tax reference numbers and, if applicable, employee / persal numbers must be indicated in paragraph 3 below. [TICK APPLICABLE]

2.8. Are you or any person connected with the bidder presently employed by the state? YES | | NO | |

2.8.1. If so, furnish the following particulars:
Name of person / director / trustee / shareholder/ member: .....
Name of state institution at which you or the person connected to the bidder is employed:.....
Position occupied in the state institution: .....Any other particulars:.....

2.8.2. If you are presently employed by the state, did you obtain the appropriate authority to undertake remunerative work outside employment in the public sector? YES | | NO | |

2.8.2.1. If yes, did you attach proof of such authority to the quote document?
(Note: Failure to submit proof of such authority, where applicable, may result in the disqualification of the quote.)

2.8.2.2. If no, furnish reasons for non-submission of such proof: .....

2.9. Did you or your spouse, or any of the company's directors / trustees / shareholders / members or their spouses conduct business with the state in the previous twelve months? YES | | NO | |

2.9.1. If so, furnish particulars:.....

2.10. Do you, or any person connected with the bidder, have any relationship (family, friend, other) with a person employed by the state and who may be involved with the evaluation and or adjudication of this quote? YES | | NO | |

2.10.1. If so, furnish particulars:.....

2.11. Are you, or any person connected with the bidder, aware of any relationship (family, friend, other) between any other bidder and any person employed by the state who may be involved with the evaluation and or adjudication of this quote? YES | | NO | |

2.11.1. If so, furnish particulars:.....

2.12. Do you or any of the directors / trustees / shareholders / members of the company have any interest in any other related companies whether or not they are bidding for this contract? YES | | NO | |

2.12.1. If so, furnish particulars:.....

3. **Full details of directors / trustees / members / shareholders.**

NB: The Department Of Health will validate **details of directors / trustees / members / shareholders** on CSD. It is the suppliers' responsibility to ensure that their details are up-to-date and verified on CSD. If the Department cannot validate the **information** on CSD, the quote will not be considered and passed over as non-compliant according to National Treasury Instruction Note 4 (a) 2016/17.

4 **DECLARATION**

I, THE UNDERSIGNED (NAME).....CERTIFY THAT THE INFORMATION FURNISHED IN PARAGRAPHS 2.

I ACCEPT THAT THE STATE MAY REJECT THE QUOTE OR ACT AGAINST ME SHOULD THIS DECLARATION PROVE TO BE FALSE.

.....	.....	.....	.....
Name of bidder	Signature	Position	Date

[1]"State" means –
a) any national or provincial department, national or provincial public entity or constitutional institution within the meaning of the Public Finance Management Act, 1999 (Act No. 1 of 1999);
b) any municipality or municipal entity;
c) provincial legislature;
d) national Assembly or the national Council of provinces; or
e) Parliament.

[2]"Shareholder" means a person who owns shares in the company and is actively involved in the management of the enterprise or business and exercises control over the enterprise.

SPECIAL CONTRACT CONDITIONS OF QUOTATIONS

1. AMENDMENT OF CONTRACT

1.1. Any amendment to or renunciation of the provisions of the contract shall at all times be done in writing and shall be signed by both parties.

2. CHANGE OF ADDRESS

2.1. Bidders must advise the Department of Health (institution where the offer was submitted) should their address (*domicilium citandi et executandi*) details change from the time of bidding to the expiry of the contract.

3. GENERAL CONDITIONS ATTACHED TO THIS QUOTATION

3.1. The institution is under no obligation to accept the lowest or any quote.
3.2. The price quoted must include VAT (if VAT vendor). However, it must be noted that the department reserves the right to evaluate all quotations excluding VAT as some bidders may not be VAT vendors.
3.3. The bidder must ensure the correctness & validity of quote:
(i) *that the price(s), rate(s) & preference quoted cover all for the work/item (s) & accept that any mistakes regarding the price (s) & calculations will be at the bidder's risk*
3.4. The bidder must accept full responsibility for the proper execution & fulfilment of all obligations conditions devolving on under this agreement, as the Principal (s) liable for the due fulfilment of this contract.
3.5. This quotation will be evaluated based on the 80/20 points system, specification & correctness of information. All required documentation must be completed in full and submitted.
3.6. Offers must comply strictly with the specification.
3.7. Only offers that meet or are greater than the specification will be considered.
3.8. Late quotes will not be considered.
3.9. Expired product/s will not be accepted. All products supplied must be valid for a minimum period of six months.
3.10. A bidder not registered on the Central Suppliers Database or verification has failed will not be considered.
3.11. All delivery costs must be included in the quote price, for delivery at the prescribed destination.
3.12. Only firm prices will be accepted. Such prices must remain firm for the contract period. Non-firm prices (including rates of exchange variations) will not be considered.
3.13. In cases where different delivery points influence the pricing, a separate pricing schedule must be submitted for each delivery point.
3.14. In the event of a bidder having multiple quotes, only the cheapest according to specification will be considered. Furthermore a verification will be done to identify if bidders have multiple companies and are quoting (cover-quoting) for this bid. In such instances only the cheapest bid according to specification will be considered.

4. SPECIAL INSTRUCTIONS AND NOTICES TO BIDDERS REGARDING THE COMPLETION OF THIS QUOTATION.

4.1. Unless inconsistent with or expressly indicated otherwise by the context, the singular shall include the plural and vice versa and with words importing the masculine gender shall include the feminine and the neuter.
4.2. Under no circumstances whatsoever may the quotation/bid forms be retyped or redrafted. Photocopies of the original bid documentation may be used, but an original signature must appear on such photocopies.
4.3. The bidder is advised to check the number of pages and to satisfy himself that none are missing or duplicated.
4.4. Quotation submitted must be complete in all respects.
4.5. Any alteration made by the bidder must be initialled.
4.6. Use of correcting fluid is prohibited
4.7. Quotation will be opened in public as soon as practicable after the closing time of quotation.
4.8. Where practical, prices are made public at the time of opening quotations.
4.9. If it is desired to make more than one offer against any individual item, such offers should be given on a photocopy of the page in question. Clear indication thereof must be stated on the schedules attached.

5. SPECIAL INSTRUCTIONS REGARDING HAND DELIVERED QUOTATIONS

5.1. Quotation shall be lodged at the address indicated not later than the closing time specified for their receipt, and in accordance with the directives in the quotation documents.
5.2. Each quotation shall be addressed in accordance with the directives in the quotation documents and shall be lodged in a separate sealed envelope, with the name and address of the bidder, the quotation number and closing date indicated on the envelope. The envelope shall not contain documents relating to any quotation other than that shown on the envelope. If this provision is not complied with, such quotations/bids may be rejected as being invalid.
5.3. All quotations received in sealed envelopes with the relevant quotation numbers on the envelopes are kept unopened in safe custody until the closing time of the quotation/bids. Where, however, a quotation is received open, it shall be sealed. If it is received without a quotation/bid number on the envelope, it shall be opened, the quotation number ascertained, the envelope sealed and the quotation number written on the envelope.
5.4. A specific box is provided for the receipt of quotations, and no quotation found in any other box or elsewhere subsequent to the closing date and time of quotation will be considered.

5.5. No quotation/bid sent through the post will be considered if it is received after the closing date and time stipulated in the quotation documentation, and proof of posting will not be accepted as proof of delivery.
5.6. Quotation documents must not be included in packages containing samples. Such quotations may be rejected as being invalid.

6. SAMPLES

6.1. In the case of the quote document stipulating that samples are required, the supplier will be informed in due course when samples should be provided to the institution. (This decreases the time of safety and storage risk that may be incurred by the respective institution). The bidders sample will be retained if such bidder wins the contract.
(i) If a company/s who has not won the quote requires their samples, they must advise the institution in writing of such.
(ii) If samples are not collected within three months of close of quote the institution reserves the right to dispose of them at their discretion.

6.2. **Samples must be made available when requested in writing or if stipulated on the document.**
(i) If a Bidder fails to provide a sample of their product on offer for scrutiny against the set specification when requested, their offer will be rejected. All testing will be for the account of the bidder.

7. COMPULSORY SITE INSPECTION / BRIEFING SESSION

7.1. Bidders who fail to attend the compulsory meeting will be disqualified from the evaluation process.

(i) The institution has determined that a compulsory site meeting ☐ take place
(ii) Date ____/____/_____ Time____:_____ Place _____

Institution Stamp:	Institution Site Inspection / briefing session Official Full Name: ..... Signature: ..... Date: .....

8. STATEMENT OF SUPPLIES AND SERVICES

8.1. The contractor shall, when requested to do so, furnish particulars of supplies delivered or services executed. If he/she fails to do so, the Department may, without prejudice to any other rights which it may have, institute inquiries at the expense of the contractor to obtain the required particulars.

9. SUBMISSION AND COMPLETION OF SBD 6.1

9.1. Should a bidder wish to qualify for preference points they must complete a SBD 6.1 document. Failure by a bidder to provide all relevant information required, will result in such a bidder not being considered for preference point's allocation. The preferences applicable on the closing date will be utilized. Any changes after the closing date will not be considered for that particular quote.

10. TAX COMPLIANCE REQUIREMENTS

10.1. In the event that the tax compliance status has failed on CSD, ***it is the suppliers' responsibility to provide a SARS pin in order for the institution to validate the tax compliance status of the supplier.***
10.2. In the event that the institution cannot validate the suppliers' tax clearance on SARS as well as the Central Suppliers Database, ***the quote will not be considered and passed over as non-compliant according to National Treasury Instruction Note 4 (a) 2016/17.***

11. TAX INVOICE

11.1. A tax invoice shall be in the currency of the Republic of South Africa and shall contain the following particulars:

(i) the name, address and registration number of the supplier;
(ii) the name and address of the recipient;
(iii) an individual serialized number and the date upon which the tax invoice is issued;
(iv) a description and quantity or volume of the goods or services supplied;
(v) the official department order number issued to the supplier;
(vi) the value of the supply, the amount of tax charged;
(vii) the words tax invoice in a prominent place.

12. PATENT RIGHTS

The supplier shall indemnify the **KZN Department of Health** (hear after known as the purchaser) against all third-party claims of infringement of patent, trademark, or industrial design rights arising from use of the goods or any part thereof by the purchaser.

13. PENALTIES

13.1. If at any time during the contract period, the service provider is unable to perform in a timely manner, the service provider must notify the institution in writing/email of the cause of and the duration of the delay. Upon receipt of the notification, the institution should evaluate the circumstances and, if deemed necessary, the institution may extend the service provider's time for performance.

13.2. In the event of delayed performance that extends beyond the delivery period, the institution is entitled to purchase commodities of a similar quantity and quality as a substitution for the outstanding commodities, without terminating the contract, as well as return commodities delivered at a later stage at the service provider's expense.

13.3. Alternatively, the institution may elect to terminate the contract and procure the necessary commodities in order to complete the contract. In the event that the contract is terminated the institution may claim damages from the service provider in the form of a penalty. The service provider's performance should be captured on the service provider database in order to determine whether or not the service provider should be awarded any contracts in the future.

13.4. If the supplier fails to deliver any or all of the goods or to perform the services within the period(s) specified in the contract, the purchaser shall, without prejudice to its other remedies under the contract, deduct from the contract price, as a penalty, a sum calculated on the delivered price of the delayed goods or unperformed services using the current prime interest rate calculated for each day of the delay until actual delivery or performance.

14. TERMINATION FOR DEFAULT

14.1. The purchaser, without prejudice to any other remedy for breach of contract, by written notice of default sent to the supplier, may terminate this contract in whole or in part:

(i) if the supplier fails to deliver any or all of the goods within the period(s) specified in the contract,

(ii) if the supplier fails to perform any other obligation(s) under the contract; or

(iii) if the supplier, in the judgment of the purchaser, has engaged in corrupt or fraudulent practices in competing for or in executing the contract.

14.2. In the event the purchaser terminates the contract in whole or in part, the purchaser may procure, upon such terms and in such manner as it deems appropriate, goods, works or services similar to those undelivered, and the supplier shall be liable to the purchaser for any excess costs for such similar goods, works or services.

14.3. Where the purchaser terminates the contract in whole or in part, the purchaser may decide to impose a restriction penalty on the supplier by prohibiting such supplier from doing business with the public sector for a period not exceeding 10 years.

15. FAILURE TO COMPLY WITH ABOVE WILL RESULT IN YOUR QUOTE BEING PASSED OVER.

PREFERENCE POINTS CLAIM FORM IN TERMS OF THE PREFERENTIAL PROCUREMENT REGULATIONS 2017

This preference form must form part of all quotes invited. It contains general information and serves as a claim form for preference points for Broad-Based Black Economic Empowerment (B-BBEE) Status Level of Contribution

NB: BEFORE COMPLETING THIS FORM, BIDDERS MUST STUDY THE GENERAL CONDITIONS, DEFINITIONS AND DIRECTIVES APPLICABLE IN RESPECT OF B-BBEE, AS PRESCRIBED IN THE PREFERENTIAL PROCUREMENT REGULATIONS, 2017.

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1. GENERAL CONDITIONS

1.1 The following preference point systems are applicable to all quotes:

- the 80/20 system for requirements with a Rand value of up to R50 000 000 (all applicable taxes included); and

1.2 The value of this quote is estimated to not exceed R50 000 000 (all applicable taxes included) and therefore the 80/20 preference point system shall be applicable.

1.3 Points for this quote shall be awarded for:
(a) Price; and
(b) B-BBEE Status Level of Contributor.

1.4 The maximum points for this quote is allocated as follows:

	POINTS
PRICE	80
B-BBEE STATUS LEVEL OF CONTRIBUTOR	20
Total points for Price and B-BBEE must not exceed	100

1.5 Failure on the part of a bidder to submit proof of B-BBEE Status level of contributor together with the quote, will be interpreted to mean that preference points for B-BBEE status level of contribution are not claimed.

1.6 The purchaser reserves the right to require of a bidder, either before a quote is adjudicated or at any time subsequently, to substantiate any claim in regard to preferences, in any manner required by the purchaser.

2. DEFINITIONS

(a) **"B-BBEE"** means broad-based black economic empowerment as defined in section 1 of the Broad-Based Black Economic Empowerment Act;

(b) **"B-BBEE status level of contributor"** means the B-BBEE status of an entity in terms of a code of good practice on black economic empowerment, issued in terms of section 9(1) of the Broad-Based Black Economic Empowerment Act;

(c) **"bid"** means a written offer in a prescribed or stipulated form in response to an invitation by an organ of state for the provision of goods or services, through price quotations, advertised competitive bidding processes or proposals;

(d) **"Broad-Based Black Economic Empowerment Act"** means the Broad-Based Black Economic Empowerment Act, 2003 (Act No. 53 of 2003);

(e) **"EME"** means an Exempted Micro Enterprise in terms of a code of good practice on black economic empowerment issued in terms of section 9 (1) of the Broad-Based Black Economic Empowerment Act;

(f) **"functionality"** means the ability of a tenderer to provide goods or services in accordance with specifications as set out in the tender documents.

(g) **"prices"** includes all applicable taxes less all unconditional discounts;

(h) **"proof of B-BBEE status level of contributor"** means:

1) B-BBEE Status level certificate issued by an authorized body or person;

2) A sworn affidavit as prescribed by the B-BBEE Codes of Good Practice;

3) Any other requirement prescribed in terms of the B-BBEE Act;

(i) **"QSE"** means a qualifying small business enterprise in terms of a code of good practice on black economic empowerment issued in terms of section 9 (1) of the Broad-Based Black Economic Empowerment Act;

(j) **"rand value"** means the total estimated value of a contract in Rand, calculated at the time of bid invitation, and includes all applicable taxes;

3. **POINTS AWARDED FOR PRICE**

3.1 **THE 80/20 PREFERENCE POINT SYSTEMS**

A maximum of 80 points is allocated for price on the following basis:

$$Ps = 80\left(1 - \frac{Pt - P\min}{P\min}\right)$$ Where

Ps = Points scored for price of bid under consideration
Pt = Price of bid under consideration
Pmin = Price of lowest acceptable bid

4. **POINTS AWARDED FOR B-BBEE STATUS LEVEL OF CONTRIBUTOR**

4.1 In terms of Regulation 6 (2) and 7 (2) of the Preferential Procurement Regulations, preference points must be awarded to a bidder for attaining the B-BBEE status level of contribution in accordance with the table below:

B-BBEE Status Level of Contributor	Number of points (80/20 system)
1	20
2	18
3	14
4	12
5	8
6	6
7	4
8	2
Non-compliant contributor	0

5. **BID DECLARATION**

5.1 Bidders who claim points in respect of B-BBEE Status Level of Contribution must complete the following:

6. **B-BBEE STATUS LEVEL OF CONTRIBUTOR CLAIMED IN TERMS OF PARAGRAPHS 1.4 AND 4.1**

6.1 B-BBEE Status Level of Contributor: = ...(maximum of 20 points)

(Points claimed in respect of paragraph 7.1 must be in accordance with the table reflected in paragraph 4.1 and must be substantiated by relevant proof of B-BBEE status level of contributor.

7. **SUB-CONTRACTING** **(Tick applicable box)**

7.1 Will any portion of the contract be sub-contracted? YES ☐ NO ☐

7.1.1 If yes, indicate:

i) What percentage of the contract will be subcontracted.....%
ii) The name of the sub-contractor.....
iii) The B-BBEE status level of the sub-contractor.....

8. Whether the sub-contractor is an EME or QSE (Tick applicable box)

iv) Specify, by ticking the appropriate box, if subcontracting with an enterprise in terms of Preferential Procurement Regulations,2017: YES ☐ NO ☐

Designated Group: An EME or QSE which is at last 51% owned by:	EME √	QSE √
Black people		
Black people who are youth		
Black people who are women		
Black people with disabilities		
Black people living in rural or underdeveloped areas or townships		
Cooperative owned by black people		
Black people who are military veterans		
OR		
Any EME		
Any QSE		

9. **DECLARATION WITH REGARD TO COMPANY/FIRM**

9.1 Name of company/firm:.....

9.2 VAT registration number:.....

9.3 Company registration number:.....

9.4 TYPE OF COMPANY/ FIRM [TICK APPLICABLE BOX]

- ☐ Partnership/Joint Venture / Consortium
- ☐ One person business/sole propriety
- ☐ Close corporation
- ☐ Company
- ☐ (Pty) Limited

9.5 DESCRIBE PRINCIPAL BUSINESS ACTIVITIES

.....

.....

9.6 COMPANY CLASSIFICATION [TICK APPLICABLE BOX]

- ☐ Manufacturer
- ☐ Supplier
- ☐ Professional service provider
- ☐ Other service providers, e.g. transporter, etc.

9.7 Total number of years the company/firm has been in business:.....

9.8 I/we, the undersigned, who is / are duly authorised to do so on behalf of the company/firm, certify that the points claimed, based on the B-BBE status level of contributor indicated in paragraphs 1.4 and 6.1 of the foregoing certificate, qualifies the company/ firm for the preference(s) shown and I / we acknowledge that:

i) The information furnished is true and correct;

ii) The preference points claimed are in accordance with the General Conditions as indicated in paragraph 1 of this form;

iii) In the event of a contract being awarded as a result of points claimed as shown in paragraphs 1.4 and 6.1, the contractor may be required to furnish documentary proof to the satisfaction of the purchaser that the claims are correct;

iv) If the B-BBEE status level of contributor has been claimed or obtained on a fraudulent basis or any of the conditions of contract have not been fulfilled, the purchaser may, in addition to any other remedy it may have –

(a) disqualify the person from the bidding process;

(b) recover costs, losses or damages it has incurred or suffered as a result of that person's conduct;

(c) cancel the contract and claim any damages which it has suffered as a result of having to make less favourable arrangements due to such cancellation;

(d) recommend that the bidder or contractor, its shareholders and directors, or only the shareholders and directors who acted on a fraudulent basis, be restricted by the National Treasury from obtaining business from any organ of state for a period not exceeding 10 years, after the *audi alteram partem* (hear the other side) rule has been applied; and

(e) forward the matter for criminal prosecution.

WITNESSES 1. ..... 2.	..... SIGNATURE(S) OF BIDDERS(S) DATE: ..... ADDRESS..... ....

1st Booklet Page 1-8

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

New-Born / Neonatal Record

WARD 01

Congratulations on Your New Baby.

Place of Delivery: KING EDWARD VIII HOSPITAL

Mother's Name: _____

ID Number: _____ *File Number:* _____

Residential Address: _____

Municipal Ward: _____

Telephone: _____ *Cell:* _____

Baby's Name: _____

File Number: _____ *Date of birth:* ____/____/____

Time of birth: _____ *Date of separation:* ____/____/____

IDENTIFICATION:			**Nurse and Mother to confirm identity of baby.**			
At birth:	Date:		Nurse:	Print: / Sign:	Mother:	Print: / Sign:
Post natal/ neonatal unit:	Date:		Nurse:	Print: / Sign:	Mother:	Print: / Sign:
At discharge:	Date:		Nurse:	Print: / Sign:	Mother:	Print: / Sign:

FINAL PROBLEM LIST:	**To be completed on Discharge:** NB Also complete RtHB.		
Problem	**Management**	**Current**	**Resolved**

Urgent treatment required and admission to neonatal unit.
Specific care and treatment now-observe with mother

FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE

Baby of: _____ Date of birth: _____

HISTORY	NB-This page only needs to be completed for babies requiring admission to the neonatal unit.	
MOTHERS DETAILS:		
Date of birth: / /	**Age:** Years.	**Name of Relative and relationship:**
Possession of ID book	Yes / No	If no- contact social worker:
Partners Name:	**Contact number:**	**Relatives contact number:**

PREVIOUS OBSTETRIC AND NEONATAL HISTORY		Complications:
No. of pregnancies:		
No. of live births:		
No. of live children:		

CURRENT OBSTETRIC HISTORY:									
Booked:	Yes / No		Clinic attendance at:		Gestation at first booking:		No of visits:		
Gestation by:	Dates: LMP: ___/___/___		Early U/S (<20 weeks) Date: ___/___/___ BPD:_____cm				SFH:		
	Weeks:		Weeks:				Weeks:		
Investigations:	Syphilis:		Blood group:				Tuberculosis:		
	Rapid Clinic	Pos / Neg	RH	Pos / Neg			Diagnosed	Yes / No	
	Rapid LW	Pos / Neg	HB:	Gm%			Date of diagnosis	__/__/__	
	RPR:		Treated:	Yes / No			Treatment started	__/__/__	
	Titre:		Last given:	No. of doses:					
HIV:	Test Result: POS / NEG / ?		ARVs started:	Yes / No			Lactation counselling:	Yes / No / Breast / Formula	
	Viral Load: copies/ml		ARV Date:	__/__/__					
	Date:	ARV Regimen:							
Med. History	Hypertension (Specify):			APH		Pyrexia		UTI	
	Diabetes	Cardiac		Epilepsy		Asthma		Vag. Disch.	
	Medications:					Allergies:			
Surg. History									
Risk factors:	Alcohol	Smoking		Illicit Drugs		GBS exposure			
	Teenage Pregnancy	Excessive weight gain		Inadequate weight gain					

CURRENT LABOUR AND DELIVERY:									
Referred from:		Reason:							
Medications:	Antenatal Steroids: (≤34 weeks gest.)	Yes / No	Antibiotics:	Yes / No	Traditional medicine:	Yes / No			
	No. of doses:		Reason:		Specify:				
	Last administered:	__/__/__	Type:						
	Time:		Started:	__/__/__					
Fetal distress:	Meconium Liquor:	Nil	Reduced foetal movements:	Yes / No	CTG:				
		Thin	Absent/reversed diastolic flow:	Yes / No	Done	Not done	Findings:		
		Thick	Foetal heart:	Norm. / Abnorm.					
Labour:	Spontaneous		1st stage:	Hrs	Mins				
	Induced		2nd stage:	Hrs	Mins				
	Oxytocin								
Ruptured membranes	Spontaneous		Date: ____/____/____		PROM≥18hrs :				
	Artificial		Time:		Offensive liquor:				
Analgesia:	Entonox		Pethidine		Time:				
	Epidural		Spinal		Gen. anaes				
Complications:	Prolapsed cord		Cord around neck		Abruptio		Praevia		

Page 3

BIRTH DETAILS:	To be completed for all babies.									
Date of birth:					**Time of birth:**					
Place:	Hospital		CHC		PHC		BBA		If BBA-how cord cut:	
Delivery:	NVD		Breech		Face		Compound			
	Vacuum		Forceps		Breech		Caesar		Reason for Caesar:	
Vital statistics:	Male		Female		Indeterminate					
	Single		Multiple		No:					
	Mass: g				**Length:** cm				**COH:** cm	
Growth:	**AGA**		**SGA**		**LGA**		**Symmetrical**		**Asymmetrical**	

ROUTINE CARE	To be completed for all babies.		
Baby dried thoroughly.	YES	NO	
Baby crying/breathing	YES	NO	If no-time baby cried:
Head covered.	YES	NO	
Nursed skin to skin.	YES	NO	If not immediately-Time started:
Covered with warm, dry cloth.	YES	NO	
Cord clamped and cut at 1-3minutes.	YES	NO	
Breast-fed within 30mins.	YES	NO	If no-Time started:

GOLDEN MINUTE	Only to be completed if baby NOT breathing following stimulation		
Head positioned with neck slightly extended.	YES	NO	
Airway cleared if mouth/nose blocked, or meconium in liquor.	YES	NO	
Baby stimulated by rubbing its back vigorously.	YES	NO	
Baby breathing.	YES	NO	
On resuscitaire: Temp probe attached and set to 36.5°C	YES	NO	
Ventilated with bag and mask within 1 min	YES	NO	Time started:
Bagged at 40-60bpm without oxygen.	YES	NO	Time bagging discontinued:

ADVANCED RESUSCITATION	Only to be completed if baby NOT breathing following ventilation or HR<60bpm		
Assistance present. Time called:	YES	NO	Time arrived:
Bagging continued with oxygen.	YES	NO	Saturations: (if available) %
Heart rate: Chest compressions commenced. Time:	YES	NO	Time compressions discontinued:
Baby intubated.	YES	NO	
IV /UV line erected.	YES	NO	
Saline /Ringers (10ml/kg IV) bolus given.	YES	NO	Volume: Time:
Adrenaline 1:10 000 (0.1-0.3ml/kg) given.	YES	NO	Dose: Time:

RESUSCITATION STOPPED	Only to be completed if baby required advanced resuscitation.		
Baby stabilised	YES	NO	Duration of resus: mins
After 10 mins if no heart rate	YES	NO	
After 20 mins if not breathing or gasping	YES	NO	
After 30 mins if gasping but not breathing	YES	NO	

APGARS	To be completed for all babies.						
Assessments	0	1	2	1min	5min	10min	20min
Appearance (Colour)	Central cyanosis	Periph. cyanosis	Pink				
Pulse	Absent	<100bpm	>100bpm				
Grimace	None	Some response	Good response				
Activity	Limp	Some flexion	Active				
Respiration	Absent	Weak/irregular	Good/cries				
Total Score:							

5min APGAR less than 7? Do Cord Gas or Arterial Blood Gas within 1 hr of birth.					
PH:		**HCO_3:**		**Lactate:**	
PCO_2:		**BE:**		**Notes:**	

PLACENTA	To be completed for all babies.									
Weight: g	Clots		Knots		Infarcts		No. of cord vessels:		Other:	

IMMEDIATE NEW-BORN CARE	To be completed for all babies.								Time:	
Identified		Cord cleaned		Eye care		Nappy		Vit. K 1mg IMI		Site:	
Baby shown to mother-Prior to transfer to Neonatal Unit		Y		N	**Temperature** prior to transfer:					°C
Neonate managed by:		**Signature:**							**Practice No.**	

Baby of: _____ Date of birth: _____

ASSESS AND CLASSIFY IMMEDIATE RISK FACTORS AND SPECIAL NEEDS.

To be completed for all newborns in labour ward:

1. If the baby has any of the 1st 5 classifications (Red) the baby has a **Problem** and should be transferred immediately to the neonatal unit.
2. If the baby has any of the remainder (Yellow) the baby is **At Risk** and should be monitored for the development of any problems with his mother.

RISK FACTOR/ PROBLEM	CLASSIFY	ACT NOW
☐ Took longer than 5 mins to breath ☐ Apgar less than 7 at 5mins ☐ Abnormal tone /not moving well	POSSIBLE NEONATAL ENCEPHALOPATHY ☐	1. Maintain temp. at 36°C ☐ 2. Assess for encephalopathy ☐ 3. Transfer to Neonatal unit ☐
☐ Major abnormality ☐ Head circumference >39cm or <32cm ☐ Alcohol, smoking or drug exposure	BIRTH ABNORMALITY ☐ RISK OF BIRTH ABNORM ☐	1. Warm baby ☐ 2. Transfer to Neonatal unit ☐ 1. Assess with mother ☐
☐ Not moving a limb ☐ Swelling of head on one side ☐ Boggy swelling of head	BIRTH INJURY ☐	1. Warm baby ☐ 2. Transfer to Neonatal unit ☐
☐ Meconium exposure **AND** one of following ☐ Grunting ☐ Chest in-drawing (Recession) ☐ Fast breathing (Tachypnoea) ☐ Central cyanosis	POSSIBLE RESPIRATORY PROBLEM ☐	1. Commence nasal prong oxygen at 1L/min ☐ 2. Transfer to Neonatal unit ☐
☐ Low birth weight less than 2kg ☐ Less than 34 weeks gestation-no steroids given	LBW / PREMATURE ☐	1. Warm baby ☐ 2. Transfer to Neonatal unit ☐
☐ Mother has diabetes ☐ Baby birth weight more than 4.0kg ☐ Mother had signs of sepsis ☐ Baby is low birth weight less than 2.5 kg or premature ☐ Baby is BBA ☐ Baby not put to breast or did not latch	INFANT OF A DIABETIC/ BIG BABY ☐ RISK OF HYPOGLYCAEMIA . ☐	1. Feed (Breast or 10ml/kg 3hrly) ☐ 2. Check blood glucose one hour after birth and then 2-3hrly ☐ 3. If glucose <2.6mmol/l post feed transfer to Neonatal unit ☐
☐ Baby is BBA ☐ Baby is low birth weight, less than 2.5 kg or premature ☐ Baby is hypoglycaemic ☐ Baby separated from mother not receiving skin to skin care	RISK OF HYPOTHERMIA ☐	1. Feed (Breast or 10ml/kg 3hrly) ☐ 2. Nurse skin to skin ☐ 3. Check temperature one hour after birth ☐ 4. If <36°C transfer to Neonatal unit ☐
☐ Mother blood group O ☐ Mother Rhesus negative ☐ Baby has birth injuries ☐ Baby is Preterm ☐ Baby has facial bruising	RISK OF JAUNDICE ☐	1. Nurse skin to skin ☐ 2. Observe colour 6hrly ☐ 3. TSB at 6hrs and 12hrly ☐ 4. Start Phototherapy if above line ☐ 5. Jaundiced on Day 1 or rapidly climbing transfer Neonatal unit ☐
☐ Membranes rupture greater than 18 hours ☐ Maternal Fever ☐ Offensive Liquor	RISK OF BACTERIAL INFECTION. ☐	1. Nurse skin to skin ☐ 2. Observe 4hrly for 24-48hrs ☐ 3. If clinical signs of infection transfer to Neonatal unit ☐
☐ Mother RPR positive ☐ Mother RPR unknown ☐ Mother RPR partially treated or treatment completed less than 1 month ago	RISK OF CONGENITAL SYPHILIS ☐	1. Give Benzathine Penicillin IMI ☐ 2. Examine for signs of syphilis ☐ 3. Transfer to Neonatal unit if signs present ☐
☐ Mother HIV positive ☐ High Viral load ☐ Mother HIV negative but not retested in the last 3 mths ☐ Mother HIV unknown ☐ Baby abandoned	RISK OF HIV TRANSMISSION ☐	1. Test mother if unknown ☐ 2. Do HIV DNA PCR ☐ 3. Refer to HIV exposure SOP ☐
☐ Mother has TB or has been on TB treatment in the last 6 months ☐ Mother coughing for more than 2 weeks	RISK OF TUBERCULOSIS ☐	1. Refer to TB exposure SOP ☐ 2. Commence TB prophylaxis/R_x ☐ 3. Give BCG on completion of Rx ☐

Assessed By:		**Signed:**		**SANC:**		**Time:**	

CLINICAL NOTES: (Record below if no risk factors are present)

Baby of: _____ Date of birth: _____

Page 5

FIRST EXAMINATION OF THE NEONATE: **To be completed for all newborns either in LW or Post Natal by nurse or doctor.**
If baby is classified in the **red area** do not examine in LW-transfer immediately to neonatal unit. Exam to be completed by nurse/doctor in neonatal unit following stabilisation.

ASSESSMENT	WELL		SICK / ABNORMAL							
Temperature	36^{5}-37°C		Hypothermic		Hyperthermic					
Appearance	Normal		Wasted		LGA		SGA		Dysmorphic	
Skin	Intact		Laceration		Rash		Petechiae		Bruising	
Colour	Pink		Pale		Plethoric		Cyanosed			
Odour	Normal		Offensive							
Respiration	40-60 bpm		Fast		Slow		Apnoea			
Cry	Normal		High pitched		Hoarse		Weak		Absent	
Behaviour	Responsive		Lethargic		Irritable		Jittery		Seizures	
Muscle tone	Normal		Hypotonic		Hypertonic		Head lag			
Moro reflex	Present & equal		Asymmetrical		Incomplete		Absent			
Sucking reflex	Present		Weak		Absent		Bites			
Rooting reflex	Present		Absent							
Grasp reflex	Present		Weak		Absent					
Plantar reflex	Present		Absent							
Walking reflex	Present		Absent							
Head shape	Normal		Caput		Asymmetrical		Haematoma		Hydrocephaly	
Fontanelles	Normal		Full/Bulging		Large		Sunken		Closed	
Sutures	Mobile		Overriding		Fused		Wide			
Face	Symmetrical		Asymmetrical		Abnormal					
Eyes	Normal		Infected		Small /Large		Slanting		Wide apart	
Ears	Normal		Malformed		Low set		Rotated		Absent	
Nose	Patent		Blocked		Flattened		Abnormal shape			
Mouth	Normal		Cleft lip		Smooth philtrum		Teeth		Cysts	
Palate	Intact		Cleft -hard palate		Cleft -soft palate					
Tongue	Normal		Large		Protruding		Tongue- tie			
Chin	Normal		Receding							
Neck	Normal		Swelling		Webbed		Nuchal fold			
Clavicles	Intact		Swelling		Crepitus		Fracture			
Nipples	Normal		Accessory (Extra)		Wide spaced		Mastitis		Absent	
Chest movement	Symmetrical		Asymmetrical		Shallow					
Recession	Absent		Intercostal		Sternal		Sub-clavicular			
Breath sounds	Quiet		Grunting		Noisy					
Heart	120-160 bpm		Tachycardia		Bradycardia		Murmur		Heard Rt. side	
Arms	Normal		Not moving		Fracture		Brachial palsy			
Fingers	Normal		Polydactyly		Syndactactyly		Hypoplastic nails			
Palmar creases	Normal		Single							
Abdomen	Normal		Distended		Scaphoid		↓/absent sounds		Gastroschisis	
Umbilicus	Normal		Bleeding		Single artery		Hernia		Exomphalus	
Hips	Normal		Dislocated		Dislocatable					
Legs	Normal		Abnormal		Not moving		Genurecuvartum			
Feet	Normal		Position deformity		Clubbed		Rocker bottom			
Toes	Normal		Polydactyly		Syndactyly		Sandal gap			
Back	Normal		Scoliosis		Meningocele		Sacral dimple		Hair tuft	
Femoral pulses	Present		Absent							
Genitalia (male)	Testes down		Undescended		Hydrocele		Inguinal hernia		Hypo/epispadius	
Genitalia (fem.)	Normal		Ambiguous		Enlarged clitoris		Fused labia			
Anus	Patent		Imperforate		**NB Part buttocks & observe anus. Meconium does not mean anus is patent!**					
Urine	Passed		Not passed							
Meconium	Passed per rectum		Not passed		**NB Ensure meconium is not passed via vaginal/urethral fistula**					

ASSESSMENT:

NB. Complete Notification Form for any congenital abnormalities noted:

Notification completed:		**Y**		**N**			
Examined by:		**Signature:**				**Designation:**	
Date:		**Time:**					
Mother notified of any abnormality:	**Y**		**N**		**Date:**	**Time:**	**Sign:**

TRANSFER TO NEONATAL UNIT / POST NATAL WARD- CONFIRM CORRECT ID BAND

Transferred by:		**Signature:**		**SANC No.**	
Received by:		**Signature:**		**SANC No.**	
Unit:		**Date:**		**Time:**	

Baby of: _____ Date of birth: _____

POST NATAL CARE **To be completed for all newborns in post natal unit.**

PLAN:

1. *Keep baby skin to skin (tied on) with mother. Discharge baby in skin to skin position*
2. *Cleansing (once warm): Wipe with warm cloth. Bath only if blood, meconium or offensive smell present. Do not remove vernix. Demonstration bath for all Primigravidas prior to discharge.*
3. *Warning signs: Transfer to neonatal unit if baby has- cyanosis; respiratory distress; persistent hypoglycaemia/ thermia; jaundice on Day 1.*
4. *All **At Risk** babies should be seen **daily** by an MO & observed at least **6hrly**. IDM, LGA,SGA - require **hourly** GMs until stable.*

OBSERVATIONS: **Complete for all well babies on admission, when reviewing mother/12hrly and on discharge.**

Date (DD/MM)												
Time												
Skin to skin-Tied on? (Y / N)												
Temperature (°C) Maintain 36.5-37°C												
Respiratory rate/distress(bpm)Norm.40-60bpm Tachypnoea >60bpm (T), Recession(R), Grunting (G)												
Heart Rate (bpm) Normal 120-160bpm												
Activity-Active and responsive? (Y / N)												
Colour -Pink(P), Pale (Pa), Jaundiced (J), Cyanosed (C)												
Blood Sugar (mmol/l) Maintain 2.5-8mmol/l **Only check if at risk/cold or not sucking.**												
Hygiene –Record any bath(B) or Wiping (W) Clean eyes & mouth daily with saline/water (C)												
Cord -Clean with Chlorhexidine tincture-✓ Note skin redness(R)/ Discharge (D)/Healthy (H)												
Mothers care of baby –Confident (C), Needs assistance (NA)												
Short line checks-6hrly Record the **location**- R/L hand (H)/ Foot (F)/Arm(A)												
Record the **condition**. Is the distal limb warm, pink & mobile (WPM) or cyanosed (C) or swollen (S)												
Sign:												

Phototherapy (Routine) Commence Phototherapy **immediately** for any sign of jaundice. If jaundiced on Day 1-transfer to neon. unit.

- *Should be given at the mother's bedside.*
- *TSB to be taken daily.*
- *Baby to be nursed naked with nappy open.*
- *Cover eyes with eyeshield (Remove during feeds)*
- *Turn 6hrly*
- *Breast feed frequently for short periods*
- *Ensure all lights are functional, as close as possible to baby and changed every 1000 hrs* **Hours of use:**_____**hrs**

Position- R/L lateral (L), Prone (P), Supine (S)												
Eyes covered- (Y / N)												
TSB (mmol/l)-Daily. **Date:**												
TSB:												
OUTPUT:												
Vomit (refer to neonatal unit if repeated/ projectile)												
Urine (No. of wet nappies)												
Stool (No. of meconium stools)												

FEEDS: Breast feed on demand (8-12 times /day)

Mother assisted with breast feeding: Hunger cues, positioning, attachment	**3hrs post-delivery-Time:**						**Sign:**					
	Before discharge-Date &Time:						**Sign:**					
Non Breast **Reason for not breast feeding**												
Non Breast **Formula feeding demonstrated**	**Date:**				**Mother demonstrated back**		Y		N			
No. of feeds												
How taken – Sucked well (SW), Weak suck (WS), Not Latching (NL), Cup (C), Syringe (S)												
Weight -Daily after Day 3. Report if more than10% weight loss.												
Sign:												

Page 7

IMMUNISATIONS:												
BCG	YES		NO		**Polio**	YES		NO		Date:		Sign:
MOTHER HIV+:	Attach HIV exposure SOP											
ARVs single prophylaxis commenced:	YES		NO		Date:		Time:					
ARVs dual prophylaxis commenced:	YES		NO		Date:		Time:					
DNA PCR taken	YES		NO		Result:		Sign:					
Education (Sign if given)	**Feeding-Baby HIV neg**	6 months exclusive & continue till 12 months										
	Feeding-Baby HIV pos	6 months exclusive & continue till 24+ months										
	Repeat testing (mother)	Viral Load every 3- 6 months										
	Avoid repeat infections	Treatment adherence & sexual health										
OTHER MEDS:												
Stipulate:		Date:		Time:								
Given by:		Signed:		Practice No.								

PRE-DISCHARGE CHECK-LIST *Discharge: Well babies -by a midwife. At risk babies must only be discharged after 24hrs- by a doctor.*					
CURRENT CONDITION:	✓	If any answer in this block is NO-do not discharge the baby	✓		
First examination completed and documented		Flexed, active and responsive (moving well)			
Complete Moro reflex		Pink- no tachypnoea or recession			
No Jaundice		Flash TSB:			
Breast feeding well		Eyes clear			
Cord clamped, not bleeding, no flare		Maintaining temperature 36^{5}-37°C			
Social work referral if teenager		All IV lines/dressings removed			
OUTPUT :					
Urine passed		Meconium passed			
IMMUNISATION AND MEDICATIONS:					
BCG & Polio		ARV's			
HEALTH EDUCATION:					
Family planning		Hand washing			
Breast feeding-exclusive, milk supply, support, duration		General hygiene			
Infant feeding-complementary feeding, preparation, amounts		Jaundice			
Thermal Care-KMC at home. Discharge in KMC position		Duration of ARV therapy			
Buttock care		Cord care			
Common problems: Sticky eyes, colic, poor sleep, diarrhoea, nappy rash		Danger signs: Cold/hot to touch, pale/blue colour, reduced activity /difficult to wake, poor feeding, vomiting/diarrhoea, fast/noisy breathing, chest indrawing, infected cord			
DOCUMENTATION:		A- Appropriate	L-Large	S-Small	GA-Gestational age
Weight plotted on percentile chart		AGA	LGA	SGA	
ID band identification confirmed by mother		Birth registration done			
RtHB completed- Pg ii ,27 and 38		RtHB given to the mother			
RtHB instructions given to mother		Referral for grant if indicated			
Follow up appointments given to mother		Clinic visits			
Sign:		**Print:**		**Desig.**	
MANAGEMENT PLAN:					
Problem list completed on cover?	**Y** / **N**	**Problem list completed-Pg. 6 RtHB?**	**Y**	**N**	

FOLLOW UP			
TYPE	**NORM**	**DATE**	**PLACE**
PHC CLINIC	All babies- 3-6 Days		
	6 Weeks		
KMC FOLLOW UP	Babies <2kg weekly till 2.5Kg		
PMTCT / PHC Clinic	For PCR result		
CCG REFERRAL	3-6 Days	**Name:**	
		Contact details:	

Discharged by: Sign:		**Print:**		**MP No.**	
Date:		**Time:**		**Discharge weight:**	**Grams**
Discharge Details above acknowledged by mother:					
Name:		**Signed:**			

Baby of: _____ Date of birth: _____

Page 8

MULTIDISCIPLINARY NOTES Consultant, doctor, nurse (only interim/crisis entries), rehab team, social worker, dietician etc.
Time, Sign, Print name and practice no. for each entry

Sample signatures:

NAME	SIGNATURE	DESIGNATION	PRACTICE NUMBER

ABBREVIATIONS

Abnorm= Abnormal; AGA= Appropriate for gestational age; ARV=Anti retro viral; APH=Ante partum haemorrhage; ARV=Anti-retroviral; BBA=Born Before arrival; BCG= Bacillus Chalmette Guerin; BE= Base Excess; BPD=Bi parietal diameter; bpm= breaths/beats per minute; CCG=Community Care giver; CHC=Community Health Centre; cm= centimetre; COH= Circumference of head; CTG=Cardiotocography; Desi.= Designation; DNA= Deoxyribonucleic acid; g=gram; GBS=Group B Streptococcus; gm= gram; GIHT= Gestationally induced hypertension; GM= Glucose monitoring; HB=Haemoglobin; HCO_3=Bicarbonate; HIV=Human immune virus; HR= Heart rate; Hr/s-Hour/s; hrly= Hourly; ID=Identification; IDM= Infant of a diabetic mother; IMI=Intramuscular injection; IV= Intravenous; Kg=Kilogram; KMC=Kangaroo mother care; LGA= Large for gestational age; LSCS=Lower segment caesarean section; LW-Labour ward; mins=Minutes; mg=milligram; MO=Medical officer; N=No; NA= Not applicable; Neg= Negative; No.=Number; Norm= Normal; NVD=normal vaginal delivery; PCO_2=Carbon dioxide; PCR=Polymerase chain reaction; Pg=Page; PHC=Primary Health care clinic; PH= Percentage of haemoglobin; PIH=Pregnancy induced hypertension; PMTCT=Prevention of mother to child transmission; PROM= Prolonged rupture of membranes; Pos= Positive; PTO= Please turn over; RH=Rhesus factor; RTHB=Road to Health Booklet; RPR= Rapid plasma regain; R_x-Treatment; SFH=Symphysis fundal height; SGA=Small for gestational age ; SOP-Standard operating procedure; TB=Tuberculosis; TSB=Total serum bilirubin; UTI=Urinary tract infection; U/S=Ultrasound; UV=Umbilical venous; Vag= Vaginal; Vit= Vitamin; Y=Yes

Baby of: ______________________ Date of birth: ______________________

2nd Booklet

Page 1 – 11

Page 1

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

PAGE NUMBER:-_____

NURSING CARE PLAN

INSTITUTION:- _____ WARD:- _____

NAME:- _____ HOSPITAL NUMBER:- _____ AGE:- _____ DIAGNOSIS:- _____

DATE	TIME	NUMBER & PROBLEMS	GOAL / EXPECTED OUTCOME	NURSING / CARE ACTIVITIES & FREQUENCY	INITIALS AND SURNAME	SANC NUMBER	SIGNATURE & RANK	DATE RESOLVED & SIGNATURE

Page 2

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

NURSING RECORD

PAGE NUMBER:-_____

INSTITUTION:- _____ WARD/DEPARTMENT:- _____ DIAGNOSIS: _____

MR / MRS / MS. SURNAME:- _____ FIRST NAME:- _____ AGE:- _____ HOSPITAL NO:- _____

MALE / FEMALE

DATE	TIME	TYPE OF ENTRY	PATIENT PROGRESS NOTES	PRINT NAME: INITIALS AND SURNAME	SANC NUMBER	SIGNATURE AND RANK

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Department:
Health
PROVINCE OF KWAZULU-NATAL

NURSING RECORD

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INSTITUTION:- _____ WARD/DEPARTMENT:- _____ DIAGNOSIS: _____

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MALE / FEMALE

DATE	TIME	TYPE OF ENTRY	PATIENT PROGRESS NOTES	PRINT NAME: INITIALS AND SURNAME	SANC NUMBER	SIGNATURE AND RANK

Page 4

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

NURSING RECORD

PAGE NUMBER:-_____

INSTITUTION:- _____ WARD/DEPARTMENT:- _____ DIAGNOSIS: _____

MR / MRS / MS. SURNAME:- _____ FIRST NAME:- _____ AGE:- _____ HOSPITAL NO:- _____

MALE / FEMALE

DATE	TIME	TYPE OF ENTRY	PATIENT PROGRESS NOTES	PRINT NAME: INITIALS AND SURNAME	SANC NUMBER	SIGNATURE AND RANK

REVIEWED DECEMBER 2016

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PROVINCE OF KWAZULU-NATAL

NURSING HISTORY: ASSESSMENT ON ADMISSION

INSTITUTION:- _____ **WARD:-** _____

PATIENT PARTICULARS (Block letters)				DIAGNOSIS						ALLERGIES:			
SURNAME:			TITLE:										
FIRST NAMES:		CALLING NAME:		HOSPITAL NUMBER		ID NUMBER:				HOME LANGUAGE:			
Mark with X	MALE:	FEMALE:	AGE:	ADMISSION DATE:		TIME OF ADMISSION				RELIGION / CULTURE:			
Property kept at owners risk		YES	NO	RESIDENTIAL ADDRESS / MUNICIPAL WARD:						DIET PREFERED:			
Property taken by relatives		YES	NO	CONTACT THE PERSON (Next of kin) NAME & NUMBER:		PATIENT'S CONTACT NUMBER:-				CURRENT OCCUPATION & OCCUPATIONAL HISTORY:			
Property annotated in Kit bBook		YES	NO										
Valuables Handed in:-	YES / NO	Valuables kept at own risk:-		YES	NO	Type of Valuables:- eg Money / Cell phone / Jewellery / firearm / other:-				Taken by:- Patient's / Relatives Signature:-			
OBSERVATIONS	VITAL SIGNS	Temp:	Pulse:	Resp:	BP:	GCS:	HGT:	PICT: eg HIV & TB Screening	Height:	HB:	LNMP:	Pregnancy Test:	
	URINALYSIS	Glucose:	Albumin:	Ketones:	Blood:	PH:	Deposits		Weight:	BMI / MUAC	Family Planning	Cervical & Breast Screening	
Presenting Problem:-													

ASSESSMENT OF: 1. **Pain:** Comfort:- (eg:- Site, severity, length, type)		**PATIENT HISTORY:** MEDICAL:					
2. **Breathing:-** (eg:- rate, depth, difficulty, sound)		SURGICAL:					
3. **Circulation:-** (eg:- colour, warmth, mobility, capillary refill, sensation)		PSYCHO-SOCIAL:					
4. **Eating and Drinking:-** (eg:- nutritional status, hydration status, type of diet, appetite, assistance)		**SOCIAL HABITS:** YES/NO	Alcohol	Drugs	Smoking	Single	Married	Divorced / Widowed
5. **Posture and Movement:-** (eg:- mobility status, position, disability, requiring assistance / aids)		**FAMILY HISTORY** YES/NO	Cancer	Diabetic	Stroke	Heart:	Arthrits	Vascular Disease

6. **Elimination:-** (eg:- urinary / stool:- amount, colour, consistency, continence, stoma)		Lungs:	Kidneys	TB	Hypertension	Mental illness	Seizures	Mental Retardation
7. **Rest and sleep:-** (eg:- habits, medication)		OTHER:						
8. **Safety:-** (eg:- mental, physical)		Current Medication	Medication brought in by Patient		Medication Taken Home		Taking Herbal Medication	
9. **Hygiene and skin:-** (eg:- rashes, bruises, pigmentation, condition)		Present Medication:						
10. **Sensory: Interpersonal Needs:-** (eg:- vision, hearing, touch)								
11. **Leaning Needs:-** (eg:- health education required)		**MARK:-** YES / NO	UNDERSTANDS CONDITION		CONDITION EXPLAINED		NAME OF RELATIVE OR CARE GIVER PRESENT:-	
12. **Social Needs:-** (eg:- grants, pension, financial, social organization's)			Waterlow Pressure Ulcer Scale Completed		Morse Fall Scale Completed		Body Inspection form complete	Patient's Rights Charter explained and documented
13. **Psychological Needs:-** (eg:- Mental State, Emotional needs)			Suicide Assessment Completed		Depression Assessment Completed		Aggression Assessment Completed	
Self-Care: or needs assistance with:- Mark Yes / No	Ambulation / Meals / Elimination / Hygiene / Dressing		Are you an Organ Donor:-				ID Band Applied	
Prosthetic Devices / Special Assist Devices :- eg artificial limb	Pressure Care Initiated							

Signature:-_____ Print Name:- _____ SANC NO:- _____

Signature:-_____ Print Name:- _____ SANC NO:- _____

COUNTERSIGNED BY PROFESSIONAL NURSE

NURSING RECORD - INITIAL ENTRY

Date	Time	Type of entry	Patient progress notes Mode of Arrival / Accompanied By / Immediate Intervention / Referral Note / Letter Other Information:- Problems needing assistance / Condition on Admission / Health Education Needs.	Print Name: Intials and Surname	SANC number	Signature and Rank.

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Morse Fall Scale

Institution: _____

Name : _____ **Ward :** _____

Hospital No. : _____ **Diagnosis :** _____

Morse Fall Scale to be used : - On admission, On transfer
When a patient's condition changes or there has been a change in Patient's medication regimen that could put the patient at risk for a fall.
After a fall.

			Date and Time			
Variables	**Numeric Values**	**Score on admission**	:	:	:	:
1. History of falling	No 0 Yes 25					
2. Secondary diagnosis	No 0 Yes 15					
3. Ambulatory Aid None/bed rest/nurse assist Crutches/cane./walker Furniture (Hold on to)	 0 15 30					
4. IV or IV Access	No 0 Yes 20					
5. Gait Normal/bed rest/Wheelchair Weak Impaired	 0 10 20					
6. Mental status Orientation to own ability Overestimates or forgets limitations	 0 15					
	Total					
	Initials					

Risk Level	**Morse Fall Scale Score**	**Action**
Low Risk	0-24	Implement Low Risk Fall Prevention Interventions
Medium Risk	25-44	Implement Medium Risk Fall Prevention Interventions
High Risk	45 and high	Implement High Risk Fall Prevention Interventions

Done by :- Name : _____ Signature: _____ SANC No:- _____ Date:- _____

Supervised by : Name : _____ Signature: _____ SANC No:- _____ Date:- _____

KEY:

STERLING PRESSURE ULCER GRADES
0. Area red, skin intact, blanchable erythema
1. Discolouration, skin, non-blanchable erythema
2. Partial skin loss involving demis and epidermis, i.e: blister
3. Wound involving subcut tissue could be necrosed
4. Wound involving subcut and/or muscle joint and/or tendons

Score	10 + At Risk	15 + High Risk	20 + Very High Risk

INITIAL ASSESSEMENT ON ADMISSION	COUNTERSIGNED BY REGISTERED NURSE
NAME:.....	NAME:.....
SIGNATURE:.....	SIGNATURE:.....
SANC No:..... DATE:.....	SANC No:..... DATE:.....

WATERLOW PRESSURE ULCER MANAGEMENT CHART

Waterflow Score on Admission	RISK STATUS	EQUIPMENT REQUIRED

Date	Time	Waterflow Score	Area at Risk	Pressure Relieving Equipment in use	Independent with position change Y/N	Frequently Advised	Sterling Grade	Management and condition of skin on pressure are pressure ulcers	Nurse's Signature	Counter sign

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BODY INSPECTION FORM / SKIN INTERGRITY NOTIFICATION

Institution : _____ Ward : _____

Patient Name : _____ Hospital Number : _____

Date of Admission : _____ Date of Notification : _____

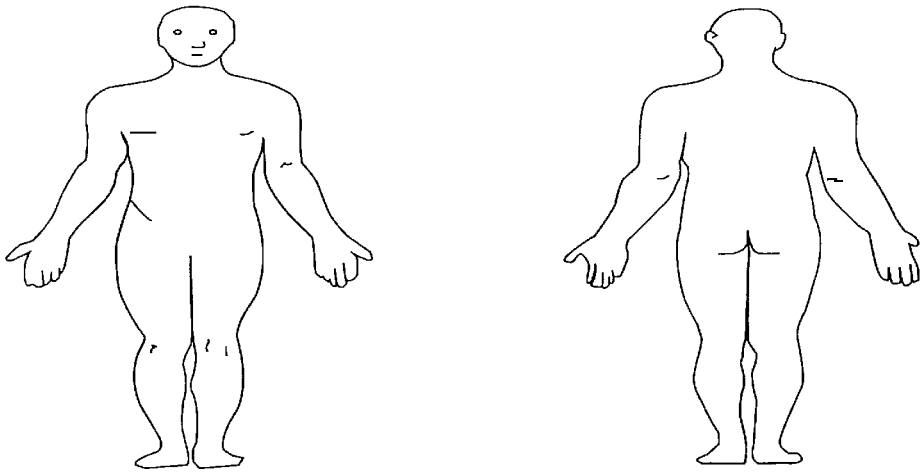
Diagnosis: _____

Origin: At Home ☐ Old Age Home ☐ Current Hospital ☐ Referring Hospital Name: _____

Other: _____

Wound Type: Trauma ☐ Abrasions ☐ Burns ☐ Surgical ☐ Other _____

Right Left Right



Anterior Posterior

Site	Location	Classification: eg Haematoma	Length	Width	Depth
Numbers:		Appearance: -eg discoloration, swelling, hard, soft etc	(cm)	(cm)	(cm)

Factors Affecting: Age: ☐ Diabetes Meliltus: ☐ Poor Nutrition: ☐ Obesity: ☐ Chemotherapy: ☐ Disease Process

Wound Healing: Other: _____

Completed By: _____ Checked By: _____

SANC Number: _____ SANC Number: _____

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WATERLOW PRESSURE ULCER SCALE

INSTITUTION:- _____

NAME OF PATIENT: _____ WARD: _____ HOSP. NO: _____

Diagnosis: Date & Time

Category	Criteria	Score	:	:	:	:	:	:	:
Bulle/Weight for Height	Average (BMI 20-24.8)	0							
	Above Average (BMI 25-29.8)	1							
	Obese (BMI >30)	2							
	Below Average (BMI <20)	3							
Skin Type & Visual Risk Areas	Healthy	0							
	Tissue Paper	1							
	Dry	1							
	Oedematous	1							
	Clammy/Pyrexia	1							
	Discoloured	2							
	Broken/Spots	3							
Gender & Age	Male	1							
	Female	2							
	14 - 49	1							
	50 - 64	2							
	65 - 74	3							
	75 - 80	4							
	80 +	5							
Appetite	Average	0							
	Poor	4							
	Nasogastric Tube/Fluid Only	2							
	Nil Per Mouth/Anorexic	3							
Continence	Complete/Catheterised	0							
	Urinary Incontinence	1							
	Faecal Incontinence	2							
	Catheterised & Incontinence of Faeces	2							
	Urinary & Faecal Incontinence	3							
Mobility	Fully	0							
	Restless/Fidgety	1							
	Apathetic	2							
	Restricted	3							
	Bed Bound	4							
	Chair Bound	5							
Tissue Malnutrition	Terminal Cachexia	8							
	Multiple Organ Failure	8							
	Single Organ Failure e.g. Cardiac, Renal, Resp	5							
	Peripheral Vascular Disease	5							
	Anaemia (Haemoglobin <8)	2							
	Smoking	1							
Neurological Deficit	Diabetes, Multiple Sclerosis, cerebrovascular Incident	4-6							
	Paraplegia/Motor/Sensory	4-6							
Major Surgery of Trauma	Orthopaedic/Spinal/Below Waist	5							
	On table more than 2 hours	5							
	On table more than 6 hours	8							
	Cytotoxics	4							
	High Dose Steriods/ Anti-Inflammatory Drugs	4							
		Total							
		Initials							

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KING EDWARD VIII HOSPITAL - MONITORING AND EVALUATION COMPONENT

INFECTION PREVENTION & CONTROL

CORONAVIRUS / COVID-2019 SCREENING TOOL

Date screened	Patient's surname/name	OP Number

SIGNS & SYMPTOMS	YES	NO
Acute respiratory infection with **sudden onset of all or some** of the following:		
1. **FEVER**		
2. **COUGH**		
3. **SHORTNESS OF BREATH**		
4. Runny nose		
5. Sore throat		
6. Headache		
7. Body pains / feeling of being unwell		
8. HISTORY OF: • Visit to countries (such as China), infected by CORONAVIRUS disease within 14 days prior to symptoms. • Having been in close contact with a confirmed or probable case of COVID-2019 infection / CORONAVIRUS disease. • Worked or attended a healthcare facility where patients with COVID-2019 infections were being treated.		