Self-injection Client Registry

Health Worker/CHW name_____ CHW #:_____ Month / Year: _____/_____

District: _____ Health facility: _____ Facility code:_____

Client #	Today's date (DD/MM/YYYY)	Is this a return visit for resupply ? (Y/N)	Client name	Client willing to be contacted for an interview ? (Y/N)	Phone number(s) where she can be reached *If client not interested in an interview, write N/A.*	Address *If client not interested in an interview, write N/A.*	Client travel time today (tick one)		Age	Client ever been to school? (Y/N)	First time using a modern method? (Y/N)	First time using an injectable? (Y/N)	Who gave the injection?		Client ready for independent self-injection ? (Y/N)	# DMPA-SC units dispensed (Include unit injected at this visit)
							Less than 1 hour	1 hour or more					Client	Provider		