

FORM C: DAILY KMC COMPLIANCE FORM

Objective: To record the number of hour of KMC given to the baby admitted in the KMC unit in 24 hours (8AM - 8AM), the duration of each session and the reason for not giving continuous KMC. To be collected by nurse on duty in KMC room via direct observation or from mother/caregiver

Day: Friday **Hospital Reg. No.:** 593628

Date of Birth(dd/mm/yy) : 07/04/2020 **Mothers Name:** rw4w4s4

S.No	Starting time of KMC	Stopping time of KMC	Duration of KMC per episode (if KMC duration >= 1 hour then record in hours if < 1 hour please record in minutes)	Reason for pausing KMC (Breast feeding, doctor checkup, mothers mealtime, mothers personal care, family visit, discomfort, complications, etc.)	KMC Provider	Nurse Name	Nurse Signature
1	12:00 PM	1:00 PM	01:00		Mother	Sita	
2							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am):						
	01:00						