

FORM A: KMC UNIT ADMISSION FORM

Objective: To be filled at the time of admission to the KMC unit, before starting long-duration KMC. The form contains information on eligibility of the baby of KMC and detail required for follow-up.

Information to be collect by nurse on duty in KMC unit from the case sheet, health officials, mother and caregivers.

Hospital Reg. No.: 6156 **MCTS No.:** --

Baby of: आंती

Date of admission to KMC unit (dd/mm/yyyy): 12/11/2018 **Time of admission** (am/pm): 07:25 AM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 12/11/2018

1.2 Sex: Female

1.3 Time of Birth (am/pm): 10:45:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 2190 grams

1.6 Place of birth: Hospital

1.6.1 Name and address of birth facility: CHC Maharajganj

1.7 Type of birth: Normal

1.8 Term of birth: Full Term/ Preterm

1.9 LMP (first day of last menstrual period - dd/mm/yyyy): 25/02/2018

1.10 Gestational age (in weeks): 37 Weeks

1.11 Weight of baby at admission to KMC unit (in grams): 2190 grams

1.12

G	P	A	L
1	1	0	1

1.13 Is the Baby stable? Yes / No

Is the baby on medication at time of admission? (Specify name and dosage)

1. _____
2. _____
3. _____

2- FAMILY DETAIL (For Follow Up)

2.1 Name of the mother: आंती

2.2 Name of the father: सार्जन

2.3 Name & relation of accompanying family member(s)

आंती

Mother

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number

Relations

9794881137

आंती

9876352842

सार्जन

2.4.1 Name and Number of ASHA: _____

2.5 Religion: Hindu

2.6 Caste: OBC

2.7 Address:

Rural/Urban: Rural

State/Country: Uttar Pradesh, India

District: Rae Bareli

Block/ Area/ Muhalla: 2056

Gram Sabha-Hamlet/ House NO.: Para Khurd

Address: नेवल गंज

Pin Code: 229103

Near: नेवल गंज

Signature of Nurse at the time of admission.

Signature of Doctor

Mandakini

15/01/2019 06:25 AM

FORM D : DAILY WEIGHT MONITORING FORM

Objective: To record the pre-feed weight of the baby admitted in the KMC unit, and compare it with the weight of the previous day and admission weight. To be filled by nurse on duty in the KMC room after weighing.

Hospital Registration Number: 6156

Mother Name: अंती

Date of Birth(dd/mm/yyyy): 12/11/2018

Birth Weight(in grams): 2190

Day	Date (dd/mm/yy)	Time of weighing	Weight of baby without clothes (in grams)	Todays weight- yesterdays weight (+, - or unchanged)	Net gain/loss since admission (Todays weight- Admission weight)	Remarks	Nurse Name	Signature or nurse talking weight
1	12/11/2018	7:27 AM	2190				Mandakini	
2	13/11/2018	3:06 AM	2100	-90	90 loss		Mansa	
3	14/11/2018	2:43 AM	1960	-140	230 loss		Swati	

Date of discharge(dd/mm/yy): 14/11/2018 **Weight of discharge(in grams):** 1990

Net gain/loss since admission(in grams)(+/-): -200

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: Monday **Hospital Reg. No.:** 6156

Date of Birth(dd/mm/yy) : 12/11/2018 **Mothers Name:** अंती

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	10:47 AM	11:56 AM	01:09		Mother	Mandakini	
2	12:01 PM	1:01 PM	01:00		Mother	Mandakini	
3	1:05 PM	2:30 PM	01:25		Grand Mother	Sanno	
4	2:35 PM	4:01 PM	01:26		Mother	Sanno	
5	4:05 PM	7:01 PM	02:56		Mother	Sanno	
6	7:50 PM	9:00 PM	01:10		Mother	Mansa	
7	9:02 PM	10:02 PM	01:00		Mother	Mansa	

8	10:55 PM	11:31 PM	00:36		Mother	Mansa	
	Total KMC duration in 24 hours (8 am to 8 am): 10:42						

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: Tuesday **Hospital Reg. No.:** 6156

Date of Birth(dd/mm/yy) : 12/11/2018 **Mothers Name:** आंती

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	12:59 AM	1:55 AM	00:56		Mother	Mansa	
2	2:03 AM	3:58 AM	01:55		Mother	Mansa	
3	4:57 AM	5:01 AM	00:04		Mother	Mansa	
4	5:30 AM	7:40 AM	02:10		Mother	Mansa	
5	8:10 AM	10:01 AM	01:51		Mother	Mandakini	
6	10:40 AM	12:01 PM	01:21		Mother	Mandakini	
7	12:20 PM	1:30 PM	01:10		Mother	Swati	
8	1:40 PM	2:45 PM	01:05		Mother	Swati	
9	3:05 PM	4:30 PM	01:25		Mother	Swati	
10	4:40 PM	6:30 PM	01:50		Mother	Swati	
11	6:45 PM	8:40 PM	01:55		Mother	Swati	
12	9:05 PM	10:15 PM	01:10		Mother	Swati	
	Total KMC duration in 24 hours (8 am to 8 am): 16:52						

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: Wednesday **Hospital Reg. No.:** 6156

Date of Birth(dd/mm/yy) : 12/11/2018 **Mothers Name:** आंती

2															
3															
4															
5															
6															
7															
8															
9															
10															
11															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 6156 **MCTS NO.:**

Name of mother: आंती **Date of discharge :** 14/11/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 64 days
weight on discharge(in grams): 1990 grams

Net weight gain/loss since admission(in grams): -200

Type of discharge : DOPR

In case of referral

Name and address of facility reffered to:

Reason for referral: _____

DISCHARGE CHECKLIST FOR KMC UNIT

Signature of Nurse/Doctor

Signature of Family Member