

## **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.**

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**Hospital Reg. No.:** 99436426842      **MCTS No.:** --

**Baby of:** Mona

**Date of admission to KMC unit** (dd/mm/yyyy): 01/01/1970 **Time of admission** (am/pm): 06:03 AM

### **1- BACKGROUND INFORMATION**

**1.1 Date of Birth** (dd/mm/yyyy): 18/11/2019

**1.2 Sex:** Female

**1.3 Time of Birth** (am/pm): 01:00:00

**1.4 type of admission:** Inborn/ Outborn

**1.5 Weight at birth** (in grams): 1965 grams

**1.6 Place of birth:**

**1.6.1 Name and address of birth facility:** Other

**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): 01/01/1970

**1.10 Gestational age** (in weeks): 2603 Weeks

**1.11 Weigth of baby at admission to KMC unit** (in grams): 2500 grams

**1.12**

G	P	A	L

**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:** Mona

**2.2 Name of the father:** \_\_\_\_\_

**2.3 Name & relation of accompanying family member(s)**

Mona \_\_\_\_\_

**2.4 Contact detail (At least 2 close contact numbers)**

**Phone / Mobile Number**

**Relations**

\_\_\_\_\_  
\_\_\_\_\_  
Mona  
\_\_\_\_\_

**2.4.1 Name and Number of ASHA:** \_\_\_\_\_

**2.5 Religion:**

**2.6 Caste:**

**2.7 Address:**

**Rural/Urban:** \_\_\_\_\_

**State/Country:** ,

**District:**

**Block/ Area/ Muhalla:**

**Gram Sabha-Hamlet/ House NO.:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Pin Code:** \_\_\_\_\_

**Near:** \_\_\_\_\_

**Signature of Nurse at the time of admission.**

**Signature of Doctor**

Nehaa  
23/12/2019 06:54 PM

\_\_\_\_\_

**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:** 99436426842

**Mother Name:** Mona

**Date of Birth(dd/mm/yyyy):** 18/11/2019

**Birth Weight(in grams):** 1965

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	03/05/2016	6:03 AM	1965				Nehaa	
2	16/12/2019	6:03 AM	1988	+23	23 gain		Nehaa	
3	16/12/2019	6:03 AM	1988	+0	23 gain		Nehaa	
4	18/12/2019	6:03 AM	1658	-330	307 loss		Seema	
5	19/12/2019	6:03 AM	2500	+842	535 gain		Seema	
6	23/12/2019	6:03 AM	2500	+0	535 gain		Nehaa	

**Date of Discharge(dd/mm/yy):** 23/12/2019 **Weight of discharge(in grams):** 5364

**Net gain/loss since admission(in grams)(+/-):** 535

### 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.:** 99436426842

**Date of Birth(dd/mm/yy) :** 18/11/2019 **Mothers Name:** Mona

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	4:00 PM	11:59 PM	07:59			Seema	
2							
3							
4							
5							

6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am):						
	07:59						

### **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:** Thursday **Hospital Reg. No.:** 99436426842

**Date of Birth(dd/mm/yy) :** 18/11/2019 **Mothers Name:** Mona

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 AM	1:00 AM	01:00			Seema	
2							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am):						
	01:00						

### **FORM B: DAILY INTAKE MONITORING RECORD**

**Objective:** To record the quantity and frequency of feeding of the baby admitted in the KMC unit in 24 hours (8 AM - 8 Am), so as to compare the total quantity to the total feeding requirement. To be filled by nurse on duty in the KMC

**Date (dd/mm/yyyy):** 01/01/1970

### Total feeding requirement for

[illegible]

## **FORM B: DAILY INTAKE MONITORING RECORD**

**Objective:** To record the quantity and frequency of feeding of the baby admitted in the KMC unit in 24 hours (8 AM - 8 Am), so as to compare the total quantity to the total feeding requirement. To be filled by nurse on duty in the KMC

**Date (dd/mm/yyyy):** 01/01/1970

### Total feeding requirement for

[illegible]

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### **DISCHARGE CHECKLIST FOR KMC UNIT**

**Hospital Reg. No.:** 99436426842      **MCTS NO.:**

**Name of mother:** Mona      **Date of discharge :**23/12/2019

**Number of days spend in KMC room (excluding days spent in SNCU/ NBSU):** 18254 days  
**weight on discharge(in grams):** 5364 grams

**Net weight gain/loss since admission(in grams):** 535

**type of discharge :** Normal Discharge

#### **In case of referral**

**Name and address of facility reffered to:**

**reason for referral:** hvmxfrshfuljvthxthx

### **DISCHARGE CHECKLIST FOR KMC UNIT**

\_\_\_\_\_  
 Signature of Nurse/Doctor

\_\_\_\_\_  
 Signature of Family Member