

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.: 177/1771 **MCTS No.:** --

Baby of: Nitu

Date of admission to KMC unit (dd/mm/yyyy): 23/11/2018 **Time of admission** (am/pm): 03:56 AM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 23/11/2018

1.2 Sex: Male

1.3 Time of Birth (am/pm): 02:45:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 2080 grams

1.6 Place of birth: Hospital

1.6.1 Name and address of birth facility: CHC Dalmau

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): 06/02/2018

1.10 Gestational age (in weeks): 41 Weeks

1.11 Weigth of baby at admission to KMC unit (in grams): 2080 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: Nitu

2.2 Name of the father: Shishankar

2.3 Name & relation of accompanying family member(s)

Nitu

Mother

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number

Relations

9146168234

Nitu

9146168234

Shishankar

2.4.1 Name and Number of ASHA: RAATRANI 7839726594

2.5 Religion: Hindu

2.6 Caste: SC

2.7 Address:

Rural/Urban: Rural

State/Country: Uttar Pradesh, India

District: Rae Bareli

Block/ Area/ Muhalla: 2049

Gram Sabha-Hamlet/ House NO.: Jagatpur Kotaha

Address: Gram Malpura Ubarni Dalmau

Pin Code: 229125

Near: Neem Ka Plant

Signature of Nurse at the time of admission.

Signature of Doctor

Manish

25/11/2018 04:48 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: 177/1771

Mother Name: Nitu

Date of Birth(dd/mm/yyyy): 23/11/2018

Birth Weight(in grams): 2080

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	23/11/2018	3:58 AM	2080				Manish	
2	24/11/2018	2:35 AM	2030	-50	50 loss		Manish	
3	25/11/2018	4:39 AM	2060	+30	20 loss		Srimati Basanti Kumari	

Date of discharge(dd/mm/yy): 25/11/2018 **Weight of discharge(in grams):** 2060

Net gain/loss since admission(in grams)(+/-): -20

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.:** 177/1771

Date of Birth(dd/mm/yy) : 23/11/2018 **Mothers Name:** Nitu

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	2:50 AM	3:41 AM	00:51		Mother	Manish	
2	4:01 AM	6:20 AM	02:19		Mother	Manish	
3	7:01 AM	8:01 AM	01:00		Mother	Manish	
4	8:10 AM	10:30 AM	02:20		Mother	Manish	
5	11:01 AM	1:01 PM	02:00		Mother	Manish	
6	1:30 PM	4:01 PM	02:31		Mother	Manish	

7	5:01 PM	6:01 PM	01:00		Mother	Manish	
8	6:30 PM	7:30 PM	01:00		Mother	Manish	
	Total KMC duration in 24 hours (8 am to 8 am): 13:01						

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Day: Saturday **Hospital Reg. No.:** 177/1771

Date of Birth(dd/mm/yy) : 23/11/2018 **Mothers Name:** Nitu

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	3:01 AM	7:01 AM	04:00		Mother	Srimati Chintamani Pal	
2	7:20 AM	8:30 AM	01:10		Mother	Srimati Rajkumari	
3	8:50 AM	11:30 AM	02:40		Mother	Srimati Rajkumari	
4	12:01 PM	2:01 PM	02:00		Grand Mother	Srimati Rajkumari	
5	2:30 PM	6:00 PM	03:30		Mother	Srimati Rajkumari	
6	6:20 PM	8:01 PM	01:41		Mother	Srimati Rajkumari	
	Total KMC duration in 24 hours (8 am to 8 am): 15:01						

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Day: Sunday **Hospital Reg. No.:** 177/1771

Date of Birth(dd/mm/yy) : 23/11/2018 **Mothers Name:** Nitu

6															
7															
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11															

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

Day : Sunday **Hospital Reg. No.:** 177/1771 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : Nitu **Baby age(in days):** 2 days **Total feeding requirement for the day:** _____

S.No.	Time of feeding (From, to)	Feeding method and measurement (fill in where applicable)								Supplements Received (name and dose)					Nurse Signature
		Direct breast feeding (in min)	Expressed breast feed (EBF) (in ml)	Mixed Feeding (in ml)				Other:* IV Type		Vit t D 3	Calciu m	HM F	Iro n	Othe r	
				EBF	Formula	Other	Net	In ml/hr	In drop/min						
1															
2															
3															
4															
5															
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Day : Sunday **Hospital Reg. No.:** 177/1771 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : Nitu **Baby age(in days):** 2 days **Total feeding requirement for the day:** _____

S.No.	Time of feeding (From, to)	Feeding method and measurement (fill in where applicable)								Supplements Received (name and dose)					Nurse Signature
		Direct breast feeding (in min)	Expressed breast feed (EBF) (in ml)	Mixed Feeding (in ml)				Other:* IV Type		Vit D 3	Calciu m	HM F	Iro n	Othe r	
				EBF	Formula	Other	Net	In ml/hr	In drop/min						
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 177/1771 **MCTS NO.:**

Name of mother: Nitu **Date of discharge :** 25/11/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 2 days
weight on discharge(in grams): 2060 grams

Net weight gain/loss since admission(in grams): -20

Type of discharge : Discharged by facility staff

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