

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

Date: April 29, 2020 8 AM - April 30, 2020 8 AM **Hospital Reg. No.:** 12580

Date of Birth(dd/mm/yy) : 30/04/2020 **Mothers Name:** Sarita

S.No	Start Date Time of KMC	Stop Date 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							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (2020-04-29 8 AM to 2020-04-30 8 AM): 00:00						

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Date: April 30, 2020 8 AM - May 1, 2020 8 AM **Hospital Reg. No.:** 12580

Date of Birth(dd/mm/yy) : 30/04/2020 Mothers Name: Sarita

S.No	Start DateTime of KMC	Stop DateTime 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							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (2020-04-30 8 AM to 2020-05-01 8 AM): 00:00						

