

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.: 5/335 **MCTS No.:** 092812606711700212

Baby of: Sundara

Date of admission to KMC unit (dd/mm/yyyy): 21/06/2018 **Time of admission** (am/pm): 11:53 AM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 21/06/2018

1.2 Sex: Female

1.3 Time of Birth (am/pm): 14:50:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 2430 grams

1.6 Place of birth: Hospital

1.6.1 Name and address of birth facility: CHC Kheero

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): 01/09/2017

1.10 Gestational age (in weeks): 42 Weeks

1.11 Weight of baby at admission to KMC unit (in grams): 2430 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: Sundara

2.2 Name of the father: Anil Kumar

2.3 Name & relation of accompanying family member(s)

Sundara

Mother

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number

Relations

7565950309

Sundara

7379041899

Anil Kumar

2.4.1 Name and Number of ASHA: Meena Devi 7839725512

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: 2054

Gram Sabha-Hamlet/ House NO.: Bhitari Gaon

Address: Bheetari Ganw

Pin Code: 229205

Near: Mandir

Signature of Nurse at the time of admission.

Signature of Doctor

Kirti

14/01/2019 01:11 PM

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: 5/335

Mother Name: Sundara

Date of Birth(dd/mm/yyyy): 21/06/2018

Birth Weight(in grams): 2430

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	21/06/2018	11:53 AM	2430					
2	22/06/2018	10:30 AM	2250	-180	180 loss			
3	23/06/2018	3:41 AM	2250	+0	180 loss			

Date of discharge(dd/mm/yy):23/06/2018 **Weight of discharge(in grams):** 2270

Net gain/loss since admission(in grams)(+/-): -160

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.:** 5/335

Date of Birth(dd/mm/yy) : 21/06/2018 **Mothers Name:** Sundara

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 PM	3:50 PM	01:00		Mother		
2							
3							
4							
5							
6							
7							

8							
	Total KMC duration in 24 hours (8 am to 8 am):						
	01:00						

FORM C: DAILY KMC COMPLIANCE FORM

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Day: Friday **Hospital Reg. No.:** 5/335

Date of Birth(dd/mm/yy) : 21/06/2018 **Mothers Name:** Sundara

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	2:00 PM	3:00 PM	01:00		Mother		
2	3:05 PM	6:00 PM	02:55		Mother		
3	6:20 PM	7:50 PM	01:30		Mother		
4	8:00 PM	9:00 PM	01:00		Mother		
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am):						
	06:25						

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Day: Saturday **Hospital Reg. No.:** 5/335

Date of Birth(dd/mm/yy) : 21/06/2018 **Mothers Name:** Sundara

1															
2															
3															
4															
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7															
8															
9															
10															
11															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 5/335 **MCTS NO.:**

Name of mother: Sundara **Date of discharge :** 23/06/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 207 days
weight on discharge(in grams): 2270 grams

Net weight gain/loss since admission(in grams): -160

Type of discharge : Normal Discharge

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