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.: 533 **MCTS No.:** --

Baby of: रोशनी

Date of admission to KMC unit (dd/mm/yyyy): 03/08/2018 **Time of admission** (am/pm): 02:21 PM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 03/08/2018

1.2 Sex: Female

1.3 Time of Birth (am/pm): 16:04:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 2390 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): 03/09/2017

1.10 Gestational age (in weeks): 48 Weeks

1.11 Weigth of baby at admission to KMC unit (in grams): 2390 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: रोशनी

2.2 Name of the father: अनिल

2.3 Name & relation of accompanying family member(s)

रोशनी	Mother

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number	**Relations**
9845325980	रोशनी
8745128000	अनिल

2.4.1 Name and Number of ASHA: _____ _____

2.5 Religion: Hindu

2.6 Caste: SC

2.7 Address:

Rural/Urban: Urban
State/Country: Uttar Pradesh, India
District: Rae Bareli
Block/ Area/ Muhalla:
Gram Sabha-Hamlet/ House NO.: Maharajganj (Np)
Address: रुद्रनागर
Pin Code: 229001
Near: Maharaj गंज

Signature of Nurse at the time of admission.	**Signature of Doctor**
Mandakini 15/01/2019 07:17 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: 533

Mother Name: रोशनी **Date of Birth(dd/mm/yyyy):** 03/08/2018

Birth Weight(in grams): 2390

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	03/08/2018	2:27 PM	2390				Mandakini	

Date of discharge(dd/mm/yy):14/08/2018 Weight of discharge(in grams): 2190

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: Friday **Hospital Reg. No.:** 533

Date of Birth(dd/mm/yy) : 03/08/2018 **Mothers Name:** रोशनी

S.No	Starting time of KMC	Stopping time of KMC	Duration of KMC per episode (if KMC duration>=1hour then record in hours if <1 hour please record in minutes)	Reason for pausing KMC (Breast feeding,doctorcheckup,mothers mealtime,mothers personal care,family visit,discomfort,complications,etc.)	KMC Provider	Nurse Name	Nurse Signature
1	8:30 PM	11:56 PM	03:26		Mother	Mandakini	
2	6:00 PM	11:59 PM	05:59		Mother	Mandakini	
3							
4							
5							
6							
7							
8							

	Total KMC duration in 24 hours (8 am to 8 am): 09:25	

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: Saturday **Hospital Reg. No.:** 533

Date of Birth(dd/mm/yy) : 03/08/2018 **Mothers Name:** रोशनी

S.No	Starting time of KMC	Stopping time of KMC	Duration of KMC per episode (if KMC duration>=1hour then record in hours if <1 hour please record in minutes)	Reason for pausing KMC (Breast feeding,doctorcheckup,mothers mealtime,mothers personal care,family visit,discomfort,complications,etc.)	KMC Provider	Nurse Name	Nurse Signature
1	12:00 AM	8:00 PM	20:00		Mother	Mandakini	
2							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am): 20:00						

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

Day : Tuesday **Hospital Reg. No.:** 533 **Date (dd/mm/yyyy)**: 01/01/1970

Mother Name : रोशनी **Baby age(in days):** 165 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							
				EBF	Formula	Other	Net	In ml/hr	In drop/min	Vit D3	Calcium	HMF	Iron	Other	
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
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 : Tuesday **Hospital Reg. No.:** 533 **Date (dd/mm/yyyy)**: 01/01/1970

Mother Name : रोशनी **Baby age(in days):** 165 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							
				EBF	Formula	Other	Net	In ml/hr	In drop/min	Vit D3	Calcium	HMF	Iron	Other	
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 533 **MCTS NO.**:

Name of mother: रोशनी **Date of discharge :**14/08/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 165 days
weight on discharge(in grams): 2190 grams

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

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