# 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.:** 6022 **MCTS No.:** --

**Baby of:** नाजमीन

**Date of admission to KMC unit** (dd/mm/yyyy): 06/11/2018 **Time of admission** (am/pm): 02:50 AM

**1-** BACKGROUND INFORMATION

**1.1 Date of Birth** (dd/mm/yyyy): 06/11/2018

**1.2 Sex:** Female

**1.3 Time of Birth** (am/pm): 06:13:00

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

**1.5 Weight at birth** (in grams): 2400 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): 05/02/2018

**1.10 Gestational age** (in weeks): 39 Weeks

**1.11 Weigth of baby at admission to KMC unit** (in grams): 2410 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:** नाजमीन

**2.2 Name of the father:** सिरताज

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

| | |
|---|---|
| नाजमीन | Mother |

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

| **Phone / Mobile Number** | **Relations** |
|---|---|
| 9554256117 | नाजमीन |
| 9875352648 | सिरताज |

**2.4.1 Name and Number of ASHA:** _____ _____

**2.5 Religion:** Muslim

**2.6 Caste:** OBC

**2.7 Address:**

**Rural/Urban:** Rural
**State/Country:** Uttar Pradesh, India
**District:** Rae Bareli
**Block/ Area/ Muhalla:** 2056
**Gram Sabha-Hamlet/ House NO.:** Halor
**Address:** समसपुर
**Pin Code:** 229103
**Near:** समसपुर

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

Mansa
15/01/2019 06:26 AM

**Signature of Doctor**

_____

## 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:** 6022

**Mother Name:** नाजमीन **Date of Birth(dd/mm/yyyy):** 06/11/2018

**Birth Weight(in grams):** 2400

| 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 | 06/11/2018 | 2:52 AM | 2410 | | | | Mansa | |

**Date of discharge(dd/mm/yy):08/11/2018 Weight of discharge(in grams):** 2490

**Net gain/loss since admission(in grams)(+/-):** 90

## 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:** Tuesday **Hospital Reg. No.:** 6022

**Date of Birth(dd/mm/yy) :** 06/11/2018 **Mothers Name:** नाजमीन

| 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 | 6:15 AM | 7:40 AM | 01:25 | | Mother | Mansa | |
| 2 | 8:15 AM | 9:15 AM | 01:00 | | Mother | Mandakini | |
| 3 | 9:30 AM | 11:30 AM | 02:00 | | Mother | Mandakini | |
| 4 | 11:45 AM | 12:30 PM | 00:45 | | Mother | Mandakini | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |

| | | |
|---|---|---|
| | Total KMC duration in 24 hours (8 am to 8 am):<br>05:10 | |

# 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.:** 6022 **Date (dd/mm/yyyy)**: 01/01/1970

**Mother Name :** नाजमीन **Baby age(in days):** 70 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Mixed Feeding (in ml) | | | | Other:* IV Type | | | | | | | |
| | | Direct breast feeding (in min) | Expressed breast feed (EBF) (in ml) | 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.:** 6022 **MCTS NO.**:

**Name of mother:** नाजमीन **Date of discharge :**08/11/2018

**Number of days spend in KMC room (excluding days spent in SNCU/ NBSU):** 70 days
**weight on discharge(in grams):** 2490 grams

**Net weight gain/loss since admission(in grams):** 90

**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