

## **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.:** 2222211      **MCTS No.:** --

**Baby of:** New Test M

**Date of Admission to KMC Unit** (dd/mm/yyyy): 21/03/2020 **Time of Admission** (AM/PM): 02:20 PM

### **1- BACKGROUND INFORMATION**

**1.1 Date of Birth** (dd/mm/yyyy): 17/03/2020

**1.2 Sex:** Male

**1.3 Time of Birth** (AM/PM): 08:00 PM

**1.4 Type of Admission:** Inborn

**1.5 Weight at Birth** (in grams): 2140 grams

**1.6 Place of Birth:**

**1.6.1 Name and Address of Birth Facility:** Other

**1.7 Type of Birth:** Assisted - Vacuum

**1.8 Term of Birth:** Full Term

**1.9 LMP** (first day of last menstrual period - dd/mm/yyyy): 18/03/2019

**1.10 Gestational Age** (in weeks): 52 Weeks

**1.11 Weigth of baby at admission to KMC unit** (in grams): 2500 grams

**1.12**

G	P	A	L

**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:** New Test M

**2.2 Name of the Father:** \_\_\_\_\_

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

New Test M

\_\_\_\_\_

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

**Phone / Mobile Number**

**Relations**

8966787887

New Test M

\_\_\_\_\_

\_\_\_\_\_

**2.4.1 Name and Number of ASHA:** \_\_\_\_\_

**2.5 Religion:**

**2.6 Caste:**

**2.7 Address:**

**Rural/Urban:** \_\_\_\_\_

**State/Country:** ,

**District:**

**Gram Sabha-Hamlet/ House NO.:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Pin Code:** \_\_\_\_\_

**Near:** \_\_\_\_\_

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

**Signature of Doctor**

\_\_\_\_\_

\_\_\_\_\_