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.: 1 **MCTS No.:** --

Baby of: Test

Date of admission to KMC unit (dd/mm/yyyy): 03/01/2020 **Time of admission** (am/pm): 03:49 PM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 02/01/2020

1.2 Sex: Male

1.3 Time of Birth (am/pm): 01:00:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 1250 grams

1.6 Place of birth:

1.6.1 Name and address of birth facility: Other

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): 01/01/1970

1.10 Gestational age (in weeks): 2609 Weeks

1.11 Weigth of baby at admission to KMC unit (in grams): 1250 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: Test

2.2 Name of the father: _____

2.3 Name & relation of accompanying family member(s)

Test _____

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number	**Relations**
_____	Test
_____	_____

2.4.1 Name and Number of ASHA: _____ _____

2.5 Religion:

2.6 Caste:

2.7 Address:

Rural/Urban: _____
State/Country: ,
District:
Block/ Area/ Muhalla:
Gram Sabha-Hamlet/ House NO.: _____
Address: _____
Pin Code: _____
Near: _____

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

Seema
03/01/2020 06:50 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: 1

Mother Name: Test **Date of Birth(dd/mm/yyyy):** 02/01/2020

Birth Weight(in grams): 1250

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	02/01/2020	6:03 AM	1250				Seema	
2	03/01/2020	6:03 AM	1580	+330	330 gain		Seema	
3	03/01/2020	6:03 AM	1250	-330	0 gain		Seema	

Date of discharge(dd/mm/yy):N/A Weight of discharge(in grams): 1250

Net gain/loss since admission(in grams)(+/-): 0

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.:**

Date of Birth(dd/mm/yy) : 01/01/1970 **Mothers Name:**

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	6:00 AM	7:00 AM	01:00		Grand Mother	Seema	
2	7:01 AM	8:00 AM	00:59		Aunty	Seema	
3							
4							
5							
6							
7							

8							
	Total KMC duration in 24 hours (8 am to 8 am): 01:59						

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 : Friday **Hospital Reg. No.:** 1 **Date (dd/mm/yyyy)**: 01/01/1970

Mother Name : Test **Baby age(in days):** 2 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.: 1 **MCTS NO.**:

Name of mother: Test **Date of discharge :**03/01/2020

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 18265 days
weight on discharge(in grams): 1250 grams

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

Type of discharge : Referral

In case of referral

Name and address of facility reffered to: SaharaGanj shdh

Reason for referral: fjjw

DISCHARGE CHECKLIST FOR KMC UNIT

_____ _____

Signature of Nurse/Doctor Signature of Family Member