

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.: 41092 **MCTS No.:** --

Baby of: पूनम

Date of admission to KMC unit (dd/mm/yyyy): 18/08/2018 **Time of admission** (am/pm): 03:51 AM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 18/08/2018

1.2 Sex: Female

1.3 Time of Birth (am/pm): 03:40:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 1890 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): 01/01/1970

1.10 Gestational age (in weeks): 2537 Weeks

1.11 Weight of baby at admission to KMC unit (in grams): 1890 grams

1.12

G	P	A	L
2	2	0	2

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: पूनम

2.2 Name of the father: अशोक कुमार

2.3 Name & relation of accompanying family member(s)

मातादेई

Aunty

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number

Relations

9304695923

पूनम

7376590693

अशोक कुमार

2.4.1 Name and Number of ASHA: _____

2.5 Religion: Hindu

2.6 Caste: General

2.7 Address:

Rural/Urban: Rural

State/Country: Uttar Pradesh, India

District: Rae Bareli

Block/ Area/ Muhalla: 2045

Gram Sabha-Hamlet/ House NO.: Pahremau

Address: गढ़ी बांगरमऊ

Pin Code: 229306

Near: पहरमऊ

Signature of Nurse at the time of admission.

Signature of Doctor

Mansa

15/01/2019 07:15 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: 41092

Mother Name: पूनम

Date of Birth(dd/mm/yyyy): 18/08/2018

Birth Weight(in grams): 1890

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	18/08/2018	3:55 AM	1890				Mansa	
2	19/08/2018	3:07 AM	1830	-60	60 loss		Swati	
3	20/08/2018	3:00 AM	1770	-60	120 loss		Sanno	
4	21/08/2018	2:57 AM	1850	+80	40 loss		Sanno	
5	22/08/2018	2:12 AM	1880	+30	10 loss		Sanno	

Date of discharge(dd/mm/yy): 22/08/2018 **Weight of discharge(in grams):** 1890

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: Saturday **Hospital Reg. No.:** 41092

Date of Birth(dd/mm/yy) : 18/08/2018 **Mothers Name:** पूनम

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	3:41 AM	5:30 AM	01:49		Mother	Mandakini	
2	6:00 AM	8:30 AM	02:30		Aunty	Mandakini	
3	8:40 AM	10:30 AM	01:50		Grand Mother	Mandakini	
4	11:00 AM	1:30 PM	02:30		Grand Mother	Sanno	

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Day: Monday **Hospital Reg. No.:** 41092

Date of Birth(dd/mm/yy) : 18/08/2018 **Mothers Name:** पूनम

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	12:00 AM	2:55 AM	02:55		Mother	Sanno	
2	3:04 AM	3:30 AM	00:26		Mother	Sanno	
3	3:33 AM	6:48 AM	03:15		Mother	Sanno	
4	7:00 AM	10:30 AM	03:30		Mother	Swati	
5	10:45 AM	11:49 AM	01:04		Mother	Swati	
6	12:15 PM	2:30 PM	02:15		Mother	Mansa	
7	2:40 PM	4:00 PM	01:20		Father	Mansa	
8	4:30 PM	7:30 PM	03:00		Mother	Mansa	
9	7:35 PM	11:00 PM	03:25		Mother	Sanno	
10	11:29 PM	11:59 PM	00:30		Mother	Sanno	
Total KMC duration in 24 hours (8 am to 8 am): 21:40							

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Day: Tuesday **Hospital Reg. No.:** 41092

Date of Birth(dd/mm/yy) : 18/08/2018 **Mothers Name:** पूनम

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

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.: 41092 Date (dd/mm/yyyy): 01/01/1970

Mother Name : पूनम **Baby age(in days):** 150 days **Total feeding requirement for the day:** _____

[illegible]

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Mother Name : पूनम **Baby age(in days):** 150 days **Total feeding requirement for the day:** _____

[illegible]

6														
7														
8														
9														
10														
11														

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Day : Tuesday **Hospital Reg. No.:** 41092 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : पूनम **Baby age(in days):** 150 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		Vit t D 3	Calciu m	HM F	Iro n	Othe r	
				EBF	Formula	Other	Net	In ml/hr	In drop/min						
1															
2															
3															
4															
5															
6															
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11															

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Day : Tuesday **Hospital Reg. No.:** 41092 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : पूनम **Baby age(in days):** 150 days **Total feeding requirement for the day:** _____

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 41092 **MCTS NO.:**

Name of mother: पूनम **Date of discharge :** 22/08/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 150 days
weight on discharge(in grams): 1890 grams

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

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