

## 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.:** 1

**Date of Birth(dd/mm/yy) : 02/01/2020 Mothers Name: Test**

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	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						