

## **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.:** 147/1167      **MCTS No.:** --

**Baby of:** Shivani

**Date of admission to KMC unit** (dd/mm/yyyy): 15/11/2018 **Time of admission** (am/pm): 11:19 AM

### **1- BACKGROUND INFORMATION**

**1.1 Date of Birth** (dd/mm/yyyy): 15/11/2018

**1.2 Sex:** Male

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

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

**1.5 Weight at birth** (in grams): 1930 grams

**1.6 Place of birth:** Hospital

**1.6.1 Name and address of birth facility:** CHC Kheero

**1.7 Type of birth:** Normal With Episiotomy

**1.8 Term of birth:** Full Term/ Preterm

**1.9 LMP** (first day of last menstrual period - dd/mm/yyyy): 24/04/2018

**1.10 Gestational age** (in weeks): 29 Weeks

**1.11 Weight of baby at admission to KMC unit** (in grams): 1930 grams

**1.12**

<b>G</b>	<b>P</b>	<b>A</b>	<b>L</b>
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:** Shivani

**2.2 Name of the father:** Shubha M

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

Shivani

Mother

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

**Phone / Mobile Number**

**Relations**

7233869805

Shivani

7233869805

Shubha M

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

**2.5 Religion:** Hindu

**2.6 Caste:** SC

**2.7 Address:**

**Rural/Urban:** Rural

**State/Country:** Uttar Pradesh, India

**District:** Unnao

**Block/ Area/ Muhalla:** 2190

**Gram Sabha-Hamlet/ House NO.:** Gulriha

**Address:** Gulariha

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

**Near:** School

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

**Signature of Doctor**

Neelam

19/11/2018 06:28 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:** 147/1167

**Mother Name:** Shivani

**Date of Birth(dd/mm/yyyy):** 15/11/2018

**Birth Weight(in grams):** 1930

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	15/11/2018	11:21 AM	1930				Neelam	
2	16/11/2018	2:36 AM	1820	-110	110 loss		Kirti	
3	17/11/2018	3:33 AM	1750	-70	180 loss		Neelam	
4	18/11/2018	2:36 AM	1800	+50	130 loss		Poornima	
5	19/11/2018	1:53 AM	1860	+60	70 loss		Poornima	

**Date of discharge(dd/mm/yy):** 19/11/2018 **Weight of discharge(in grams):** 1850

**Net gain/loss since admission(in grams)(+/-):** -80

### 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.:** 147/1167

**Date of Birth(dd/mm/yy) :** 15/11/2018 **Mothers Name:** Shivani

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	11:50 AM	1:30 PM	01:40		Mother	Neelam	
2	1:50 PM	3:01 PM	01:11		Mother	Neelam	
3	3:30 PM	4:30 PM	01:00		Mother	Neelam	
4	4:50 PM	6:35 PM	01:45		Mother	Kirti	
5	7:00 PM	8:35 PM	01:35		Mother	Kirti	

6	8:55 PM	10:40 PM	01:45		Mother	Kirti	
7	11:00 PM	11:59 PM	00:59		Mother	Kirti	
	Total KMC duration in 24 hours (8 am to 8 am): 09:55						

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**Day:** Friday **Hospital Reg. No.:** 147/1167

**Date of Birth(dd/mm/yy) :** 15/11/2018 **Mothers Name:** Shivani

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	12:01 AM	12:55 AM	00:54		Mother	Kirti	
2	1:12 AM	3:01 AM	01:49		Mother	Kirti	
3	3:21 AM	5:15 AM	01:54		Mother	Kirti	
4	5:35 AM	7:20 AM	01:45		Mother	Kirti	
5	7:30 AM	8:05 AM	00:35		Other	Kirti	
6	8:10 AM	9:01 AM	00:51		Mother	Neelam	
7	9:30 AM	10:30 AM	01:00		Mother	Neelam	
8	11:01 AM	12:30 PM	01:29		Mother	Neelam	
9	1:01 PM	2:30 PM	01:29		Mother	Neelam	
10	1:01 PM	2:30 PM	01:29		Mother	Neelam	
11	3:01 PM	4:30 PM	01:29		Mother	Neelam	
12	5:01 PM	7:30 PM	02:29		Mother	Poornima	
13	8:15 PM	10:20 PM	02:05		Mother	Poornima	
	Total KMC duration in 24 hours (8 am to 8 am): 19:18						

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**Day:** Saturday **Hospital Reg. No.:** 147/1167

**Date of Birth(dd/mm/yy) :** 15/11/2018 **Mothers Name:** Shivani

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	8:30 AM	9:30 AM	01:00		Mother	Neelam	
2	9:50 AM	10:55 AM	01:05		Mother	Neelam	
3	11:15 AM	12:55 PM	01:40		Mother	Kirti	
4	1:10 PM	2:20 PM	01:10		Grand Mother	Kirti	
5	3:01 PM	4:30 PM	01:29		Mother	Poornima	
6	5:01 PM	6:50 PM	01:49		Mother	Poornima	
7	7:19 PM	9:01 PM	01:42		Mother	Poornima	
Total KMC duration in 24 hours (8 am to 8 am): 09:55							

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**Day:** Sunday **Hospital Reg. No.:** 147/1167

**Date of Birth(dd/mm/yy) :** 15/11/2018 **Mothers Name:** Shivani

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	12:01 AM	2:15 AM	02:14		Mother	Poornima	
2	2:40 AM	4:20 AM	01:40		Mother	Poornima	
3	4:50 AM	5:45 AM	00:55		Mother	Neelam	
4	6:10 AM	7:01 AM	00:51		Mother	Neelam	



## 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 :** Monday      **Hospital Reg. No.:** 147/1167      **Date (dd/mm/yyyy):** 01/01/1970

**Mother Name :** Shivani      **Baby age(in days):** 4 days      **Total feeding requirement for the day:** \_\_\_\_\_

[illegible]

## FORM B: DAILY INTAKE MONITORING RECORD

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**Day :** Monday      **Hospital Reg. No.:** 147/1167      **Date (dd/mm/yyyy):** 01/01/1970

**Mother Name :** Shivani      **Baby age(in days):** 4 days      **Total feeding requirement for the day:**

[illegible]

6															
7															
8															
9															
10															
11															

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**Day :** Monday      **Hospital Reg. No.:** 147/1167      **Date (dd/mm/yyyy):** 01/01/1970

**Mother Name :** Shivani      **Baby age(in days):** 4 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															
7															
8															
9															
10															
11															

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**Day :** Monday      **Hospital Reg. No.:** 147/1167      **Date (dd/mm/yyyy):** 01/01/1970

**Mother Name :** Shivani      **Baby age(in days):** 4 days      **Total feeding requirement for the day:** \_\_\_\_\_





## **DISCHARGE CHECKLIST FOR KMC UNIT**

**Hospital Reg. No.:** 147/1167      **MCTS NO.:**

**Name of mother:** Shivani      **Date of discharge :** 19/11/2018

**Number of days spend in KMC room (excluding days spent in SNCU/ NBSU):** 4 days  
**weight on discharge(in grams):** 1850 grams

**Net weight gain/loss since admission(in grams):** -80

**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**

1. Stable and not on parenteral medication, the baby's general health is good and there is no concurrent disease such as apnoea or infection
2. Maintaining temperature in the KMC position and mother's bed for 3 consecutive days at room temperature
3. Gaining 15-20 grams per day for at least 3 consecutive days
4. Accepting feeds directly from breast (preferable) or by spoon, paladai or cup, he is feeding well, and is exclusively or predominantly breastfed
5. The mother is confident in caring for the baby and is able to come regularly for follow-up visits. At discharge, the mother and family members must be taught to ensure that the infant is nursed in a warm room and is breastfed (Given expressed milk using paladai or cup). They should be adequately told about hygiene, danger signs, follow-up visits, immunization and prompt care seeking at a health facility. KMC should be continued as long as required and baby and mother should not be discharged in a hurry.

\_\_\_\_\_  
Signature of Nurse/Doctor

\_\_\_\_\_  
Signature of Family Member