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.: 6 **MCTS No.:** --

Baby of: Unknown

Date of Admission to KMC Unit (dd/mm/yyyy): 15/01/2020 **Time of Admission** (AM/PM): 03:59 PM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 20/12/2019

1.2 Sex: Female

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

1.4 Type of Admission: Inborn

1.5 Weight at Birth (in grams): 2678 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: N/A

1.9 LMP (first day of last menstrual period - dd/mm/yyyy): _____

1.10 Gestational Age (in weeks): UNKNOWN

1.11 Weigth of baby at admission to KMC unit (in grams): 2958 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: _____

2.2 Name of the Father: _____

2.3 Name & relation of accompanying family member(s)

Saima Unknown

2.4 Contact Detail (At least 2 close contact numbers)

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

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: _____
Pincode: _____
Near: _____

3- ORGANISATION DETAIL

3.1 Organisation Name: Gfjuyrssrukcrxy
3.2 Organisation Number: 8066736974
3.3 Organisation Address: Dltuvkyrmxb6og5id

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

Seema
15/01/2020 05:28 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: 6

Mother Name: **Date of Birth(dd/mm/yyyy):** 20/12/2019

Birth Weight(in grams): 2678

Day	Date (dd/mm/yyyy)	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	Baby picture with weighing machine
1	20/12/2019	6:03 AM	2678				Seema	N/A
2	15/01/2020	6:03 AM	3000	+322	322 gain		Seema	
3	15/01/2020	6:03 AM	2958	-42	280 gain		Seema	

Date of discharge(dd/mm/yy):N/A Weight of discharge(in grams): 2958

Net gain/loss since admission(in grams)(+/-): 280

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 (8 AM - 8 AM), 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: Tuesday **Hospital Reg. No.:** 6

Date of Birth(dd/mm/yyyy) : 20/12/2019 **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	1:00 PM	07:00		Grand Mother	Seema	
2							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 AM to 8 AM): 07:00						

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 : Wednesday **Hospital Reg. No.:** 6 **Date (dd/mm/yyyy)**: 15/01/2020

Mother Name : **Baby Age(in days):** 27 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	6:00 AM														
2	8:00 AM		38												
3															
4															
5															
6															
7															
8															
9															
10															
11															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 6 **MCTS NO.**: --

Name of Mother: **Date of Discharge :**15/01/2020

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 0 days
Weight on Discharge(in grams): 2958 grams

Net weight gain/loss since admission(in grams): 280

Type of Discharge : Referral

In case of referral

Name and address of facility reffered to: DWH VAB Lko yvkjtxfylxd

Reason for Referral: b,khdy4ful

_____ _____

Signature of Nurse/Doctor Signature of Family Member