

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.: 595/2915 **MCTS No.:** --

Baby of: Sadhana

Date of admission to KMC unit (dd/mm/yyyy): 10/11/2018 **Time of admission** (am/pm): 06:33 AM

1- BACKGROUND INFORMATION

1.1 Date of Birth (dd/mm/yyyy): 10/11/2018

1.2 Sex: Female

1.3 Time of Birth (am/pm): 07:57:00

1.4 Type of admission: Inborn/ Outborn

1.5 Weight at birth (in grams): 2290 grams

1.6 Place of birth: Hospital

1.6.1 Name and address of birth facility: CHC Kheero

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): 26/02/2018

1.10 Gestational age (in weeks): 37 Weeks

1.11 Weight of baby at admission to KMC unit (in grams): 2290 grams

1.12

G	P	A	L
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: Sadhana

2.2 Name of the father: Rambahadur

2.3 Name & relation of accompanying family member(s)

Sadhana

Mother

2.4 Contact detail (At least 2 close contact numbers)

Phone / Mobile Number

Relations

9198993845

Sadhana

9198993845

Rambahadur

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: Rae Bareli

Block/ Area/ Muhalla: 2054

Gram Sabha-Hamlet/ House NO.: Shiv Puri

Address: Nandheri Khera Shivpuri Khiron Rbl

Pin Code: 229209

Near: Talab

Signature of Nurse at the time of admission.

Signature of Doctor

Poornima

12/11/2018 11:32 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: 595/2915

Mother Name: Sadhana

Date of Birth(dd/mm/yyyy): 10/11/2018

Birth Weight(in grams): 2290

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	10/11/2018	6:34 AM	2290				Poornima	
2	11/11/2018	2:12 AM	2170	-120	120 loss		Kirti	
3	12/11/2018	3:34 AM	2090	-80	200 loss		Neelam	

Date of discharge(dd/mm/yy): 12/11/2018 **Weight of discharge(in grams):** 2120

Net gain/loss since admission(in grams)(+/-): -170

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.:** 595/2915

Date of Birth(dd/mm/yy) : 10/11/2018 **Mothers Name:** Sadhana

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	7:58 AM	9:01 AM	01:03		Mother	Poornima	
2	9:25 AM	12:01 PM	02:36		Mother	Poornima	
3	12:50 PM	2:30 PM	01:40		Mother	Poornima	
4	3:01 PM	5:01 PM	02:00		Mother	Poornima	
5	5:20 PM	7:05 PM	01:45		Mother	Kirti	
6	7:25 PM	9:10 PM	01:45		Mother	Kirti	
7	9:30 PM	10:50 PM	01:20		Mother	Kirti	

8	11:06 PM	11:59 PM	00:53		Mother	Kirti	
	Total KMC duration in 24 hours (8 am to 8 am): 13:02						

FORM C: DAILY KMC COMPLIANCE FORM

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Day: Sunday **Hospital Reg. No.:** 595/2915

Date of Birth(dd/mm/yy) : 10/11/2018 **Mothers Name:** Sadhana

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	12:20 AM	2:05 AM	01:45		Mother	Kirti	
2	2:30 AM	4:10 AM	01:40		Mother	Kirti	
3	4:30 AM	6:15 AM	01:45		Mother	Kirti	
4	6:35 AM	7:40 AM	01:05		Mother	Kirti	
5	8:30 AM	10:01 AM	01:31		Mother	Neelam	
6	11:01 AM	12:55 PM	01:54		Mother	Neelam	
7	1:30 PM	2:30 PM	01:00		Mother	Neelam	
8	3:01 PM	4:10 PM	01:09		Mother	Neelam	
9	4:30 PM	6:25 PM	01:55		Mother	Kirti	
10	6:40 PM	8:25 PM	01:45		Mother	Kirti	
11	8:46 PM	10:04 PM	01:18		Mother	Kirti	
12	10:35 PM	11:57 PM	01:22		Grand Mother	Kirti	
	Total KMC duration in 24 hours (8 am to 8 am): 18:09						

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Day: Monday **Hospital Reg. No.:** 595/2915

Date of Birth(dd/mm/yy) : 10/11/2018 Mothers Name: Sadhana

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	12:21 AM	2:10 AM	01:49		Mother	Kirti	
2	2:25 AM	4:10 AM	01:45		Mother	Kirti	
3	4:25 AM	6:05 AM	01:40		Mother	Kirti	
4							
5							
6							
7							
8							
Total KMC duration in 24 hours (8 am to 8 am): 05:14							

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.:** 595/2915 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : Sadhana **Baby age(in days):** 2 days **Total feeding requirement for the day:**

[illegible]

6															
7															
8															
9															
10															
11															

FORM B: DAILY INTAKE MONITORING RECORD

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Day : Monday **Hospital Reg. No.:** 595/2915 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : Sadhana **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		Vit 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.:** 595/2915 **Date (dd/mm/yyyy):** 01/01/1970

Mother Name : Sadhana **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		Vit 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															

DISCHARGE CHECKLIST FOR KMC UNIT

Hospital Reg. No.: 595/2915 **MCTS NO.:**

Name of mother: Sadhana **Date of discharge :** 12/11/2018

Number of days spend in KMC room (excluding days spent in SNCU/ NBSU): 2 days
weight on discharge(in grams): 2120 grams

Net weight gain/loss since admission(in grams): -170

Type of discharge : Discharged by facility staff

In case of referral

Name and address of facility referred to:

Reason for referral: _____

DISCHARGE CHECKLIST FOR KMC UNIT

Signature of Nurse/Doctor

Signature of Family Member