**Date ………………………………**

**DISCHARGE SLIP**

|  |  |
| --- | --- |
| No. of days baby stayed in Hospital **(in Days)** |  |
| No. of days baby stayed in KMC unit **(in Days)** |  |
| Weight at the time of admission in KMC Unit **(in grams)** |  |
| Weight at the time of discharge **(in grams)** |  |
| Total weight gain during KMC Unit Stay **(in grams)** |  |
| Temperature at the time of Discharge |  \_\_\_\_\_\_\_**° F** |

|  |  |  |
| --- | --- | --- |
| **Sr. No.** | **Discharge criteria** | **Yes / No** |
| **1.** | Baby Stable (A,B,C) |  |
| **2.** | Baby not on parenteral medication |  |
| **3.** | Baby Maintaining temperature in Mother`s bed for 3 consecutive days at room temperature |  |
| **4.** | Gaining 15-20 grams per day at least for 3 consecutive Days |  |
| **5.** | Accepting breastfeed (preferable) / by spoon / paldai / feeding cup |  |

|  |
| --- |
| **Mother & Family Members Counselled regarding KMC by:** |
| Name |  |
| Designation |  |
| Duration of Counselling (In minutes) |  |
| Counselling Given to |  |

**Signature**

**Discharge Advice & Instructions:**

**Discharged By**

**(Name & Designation)**