FORM 'F' [See Proviso to Section 4(3),Rule 9(4) and Rule 10(1A)]

FORM FOR MAINTENANCE OF RECORD IN CASE OF PRENATAL DIAGNOSTIC TEST/ PROCEDURE BY GENETIC CLINIC/ ULTRASOUND CLINIC/ IMAGING CENTRE

Section A: To Be Filled In For All Diagnostic Procedures / Tests	
1. Name and Complete Address of Genetic Clinic/ Ultrasound Clinic/ Imaging Centre:	**Balasaheb Deoras Polyclinic** **Ground, 1st and 2nd Floor, A Wing, Aditya Park, Sr. No. 59, Part Kondhwa Budruk, Pune - 411048**
2. Registration No. (Under PC& PNDT Act, 1994):	**1037/2019**
3. Patient's Name:	
4. Total Number of living children:	
(a) Number of living Sons with age of each living Son:	
(b) Number of living Daughters with age of each living Daughter:	
5. Husband's/ Wife's/ Father's/ Mother's Name:	
6. Full Postal Address of the Patient with Contact No:	
7. (a) Referred By (Full name and address of Doctor(s)/ Genetic Counseling Centre):	
(b) Self- Referral by Gynaecologist/ Radiologist/ Registered Medical Practitioner Conducting the Diagnostic Procedures: --Not Applicable-- (Referral note with indications and case papers of the patient to be preserved with Form F) (Self- referral does not mean a client coming to a clinic and requesting for the test or the relative/s requesting for the test of a pregnant woman)	
8. Last menstrual period or weeks of pregnancy:	

Section B: To Be Filled In For Performing Non-Invasive Diagnostic Procedures/ Tests Only	
9. Name of Doctor Performing the Procedures:	
10. Indication/s for Diagnosis Procedure:_____ (specify with reference to the request made in the referral slip or in a self- referral note) (Ultrasonography prenatal diagnosis during pregnancy should only be performed when indicated. The following is the representative list of indications for ultrasound during Pregnancy). (Put a 'TICK' against the appropriate indication/s for ultrasound)	
[i.] To diagnose intra-uterine and/ or ectopic pregnancy and confirm viability.	[xiii.] Preterm labour / preterm premature rupture of membranes.
[ii.] Estimation of gestational age (dating).	[xiv.] Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental hemorrhage, abnormal adherence etc.).
[iii.] Detection of number of fetuses and their chorionicity.	[xv.] Evaluation of umbilical cord - presentation, insertion, nuchal encirclement, number of vessels and presence of true knot.
[iv.] Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure/ MTP failure.	[xvi.] Evaluation of previous Caesarean Section scars.
[v.] Vaginal bleeding / leaking.	[xvii.] Evaluation of fetal growth parameters, fetal weight and fetal well being.
[vi.] Follow-up of cases of abortion.	[xviii.] Colour flow mapping and duplex Doppler studies.
[vii.] Assessment of cervical canal and diameter of internal os.	[xix.] Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc. and their follow-up.
[viii.] Discrepancy between uterine size and period of amenorrhea.	[xx.] Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVS), amniocenteses, fetal blood sampling, fetal skin biopsy, amnio-infusion, intrauterine infusion, placement of shunts etc.
[ix.] Any suspected adenexal or uterine pathology / abnormality.	[xxi.] Observation of intra-partum events.
[x.] Detection of chromosomal abnormalities,fetal structural defects and other abnormalities and their followup.	[xxii.] Medical/ surgical conditions complicating pregnancy.
[xi.] To evaluate fetal presentation and position.	[xxiii.] Research/ scientific studies in recognized institutions.
[xii.] Assessment of liquor amnii.	

11. Procedure carried out(Non-Invasive) (Put a 'TICK' on the appropriate procedure): i. Ultrasound [✔] (Important Note: Ultrasound is not indicated/ advised/ performed to determine the sex of fetus except for diagnosis of sex linked diseases such as Duchene Muscular Dystrophy, Hemophillia A & B etc.) ii. Any Other (specify) --Not Applicable--
12. Date on Which declaration of pregnant woman/person was obtained:
13. Date on Which Procedures carried out:
14. Result of the non-invasive procedure carried out (report in brief of the test including ultrasound carried out): Normal / Abnormal
15. The result of pre-natal diagnostic procedures was conveyed to:
16. Any indication for MTP as per the abnormality detected in the diagnostic procedures/ tests:

Date:
Place:

Doctor Signature:Name in Capitals, Registration Number with Seal of the Gynaecologist/ Radiologist/ Registered Medical Practitioner Conducting Diagnostic Procedure

SECTION C: To be filled for performing invasive Procedures/Tests only (Not Applicable for this Clinic/Lab)
17. Name of the doctor/s performing procedure/s:
18. History of genetic/medical disease in the family (specifiy): Basis of Diagnosis('Tick' on appropriate basis of diagnosis): (a) Clinical (b) Bio-chemical (c) Cytogenetic (d) Other (e.g. radiological, ultrasonography, etc.- specify)
19. Indication/s for the diagnosis procedure ('Tick' on appropriate indication/s): A. Previous child/children with: (i) Chromosomal Disorders (ii) Metabolic Disorder (iii) Congenital Anomaly (iv) Mental Disability (v) Haemoglobinopathy (vi) Sex Linked Disorders (vii) Single Gene Disorders (viii) Any Other (specify) B. Advanced maternal age (35 years): C. Mother/ Father/ Sibling has genetic disease (specify): D. Other (specify):
20. Date on which consent of pregnant women/ person was obtain in Form G prescribed in PC&PNDT Act, 1994:
21. Invasive procedures carried out('Tick' on appropriate indication's): (i) Amniocentesis (ii) Chorionic Villi Aspiration (iii) Fetal Biopsy (iv) Cordocentesis (v) Any Other (specify)
22. Any complication of invasive procedure (specify):
23. Additional tests recommended (Please mention if applicable) (i) Chromosomal studies (ii) Biochemical studies (iii) Molecular studies (iv) Pre - implantation gender diagnosis (v) Any other (specify):
24. Result of the Procedures/ Tests carried out (report in brief of the invasive/ procedures carries out): -- Not Applicable --
25. Date on which procedures carried out: -- Not Applicable --
26. The result of pre-natal diagnostic procedures was conveyed to on : -- Not Applicable --
27. Any indication for MTP as per the abnormality detected in the diagnostic procedures/ tests: -- Not Applicable --
Date: / / Place: Name, Signature and Registration Number with Seal of the Gynaecologist/ Radiologist/ Registered Medical Practitioner performing Diagnostic Procedure/s

Section D: Declaration

DECLARATION OF THE PERSON UNDERGOING PRENATAL DIAGNOSTIC TEST/ PROCEDURE

I, _____ declare that by undergoing Ultrasonography Prenatal Diagnostic Test/ Procedure. I do not want to know the sex of my fetus.

Date:
Place:

Signature/ Thumb impression of the person
Undergoing the Prenatal Diagnostic Test/ Procedure

In Case of thumb Impression:

Identified by (Name)_____ Age: _____ Sex: _____

Relation (if any):_____ Address & Contact No.: _____

_____

Signature of a person attesting thumb impression: _____ Date:_____

DECLARATION OF THE DOCTOR/PERSON CONDUCTING PRENATAL DIAGNOSTIC TEST/ PROCEDURE

I, _____ (name of the person conducting Ultrasonography / image scanning) declare that while conducting Ultrasonography / image scanning on _____ (name of the pregnant woman or the person undergoing pre natal diagnostic procedure/ test), I have neither detected nor disclosed the sex of her fetus to anybody in any manner.

Date:
Place:

Signature:Name in Capitals, Registration Number with Seal of the Gynaecologist/ Radiologist/ Registered Medical Practitioner Conducting Diagnostic Procedure

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