**FORM ‘F’ FOR MAINTENANCE OF RECORD IN CASE OF PRENATAL DIAGNOSIS TEST /**

**PROCEDURE BY GENETIC CLINIC / ULTRASOUND CLINIC / IMAGING CENTRE**

**[See Provision to Section 4 (3), Rule 9 (4) and Rule 10 (1 A)]**

**Section A: To be filled in for all Diagnostic Procedures / Tests**

1 **.SHRADDHA HOSPITAL, Sr. No. 43, Parashar Soc., Pune- Nagar Road, Chandannagar, Kharadi, Pune-14**

2 **.**Registration No. (Under PC& PNDT Act. 1994 ) : **550/2012**

3 . Patient’s Name: ............................................................................................................. Age: ........... yrs

4. Total Number of living children: ..........

(a) Number of living sons with age of each living son\*(in years or months): (.................................................................)

(b) Number of living daughters with age of each daughter (in years or months): (..................................................................)

. 5. Husband’s/Wife/Father’s/Mother’s Name: .....................................................................................................................

6. Address of the patient: ...................................................................................................................... Contact No. **:** ............................ Referred by : **Dr.ShraddhaJadhav (Shraddha Hospital Sr. No. 43, Parashar Soc., Pune- Nagar Road, Chandannagar, Kharadi, Pune-14)**

(b) Self Referral :**N A**

8. Last menstrual period : / / Weeks of pregnancy: wks.

**Section B : To be filled in for performing non-invasive diagnostic procedures / test only**

9. Name of the doctor performing the procedure/s : DR. SANJIV S. JADHAV, MBBS, DGO, Regd. No.60876

10. Indication/s for diagnostic procedure(

I To diagnose intra-uterine and/or ectopic pregnancy and confirm viability.

ii Estimation of gestational age (Dating)

iii Detection of number of foetuses and their chorionicity

iv Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure/MTP failure.

V Vaginal bleeding/leaking.

Vi Follow-up cases of abortion.

Vii Assessment of cervical canal and diameter of internal os.

Viii Discrepancy between uterine size and period of amenorrhea.

Ix Any suspected adnexal or uterine pathology/abnormality.

X Detection of chromosomal abnormalities, fetal structural defects and other abnormalities and their follow-up.

Xi To evaluate fetal presentation and position.

Xii Assessment of liquor amnii.

Xiii Preterm labor premature rupture of membranes.

Xiv Evaluation of placental position,thicknees,grading and abnormalities(placenta praevia,retro placental haemorrhage,abnormal adherence etc.)

Xv Evaluation of umbilical cord-presentation, insertion nuchal encirclment, number of vessels and presence of true knot.

Xvi Evaluation of previous Caesarean Section scars.

Xvii Evaluation of fetal growth paramenters, fetal weight and fetal well-being.

Xviii Color flow mapping and duplex Doppler studies.

Xix Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version ect.and their follow-up.

Xx Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVC), amniocenteses, fetal blood sampling,fetal

Skin biopsy, amnio-infusion, intrauterine infusion, placement of shunts ect..

Xxi Observation of intra-partum events.

Xxii Medical/surgical conditions complicating pregnancy.

Xxiii Research/scientific studies in recognized institutions.

11. Procedures carried out (Non-invasive) (i) Ultrasound (ii) Any other- Nil

12. Date on which declaration of pregnant woman/person was obtained : / /

13. Date on which procedure carried out : / /

14. Result of the non-invasive procedure out (report in brief of the test including ultrasound carried out) :

15 . The results of pre-natal diagnostic procedure were conveyed to .................................................................... On / /

16. Any indication for MTP : **No**

Place : Chandannagar, Pune

Date :. / / Signature

**Section C: To be filled for performing invasive Procedures/ Tests only: NOT APPLICABLE**

17. Name of the doctor/s performing the procedure/s: NOT APPLICABLE

18. History of genetic/medical disease in the family (specify): NOT APPLICABLE

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): NOT APPLICABLE

A. Previous child/children with: (i) Chromosomal disorders (ii) Metabolic disorders (iii) Congenital anomaly (iv) Mental disability (v) Haemoglobinopathy (vi) Sex linked disorders (vii) Single gene disorder (viii) Other B. Advanced maternal age (35 years) C. Mother/father/sibling has genetic disease (specify) D. Other: NOT APPLICABLE

20. Date on which consent of pregnant woman / person was obtained in Form G prescribed in PC&PNDT Act, 1994: NOT APPLICABLE

21. Invasive procedures carried out (“Tick” on appropriate indication/s): NOT APPLICABLE

i. Amniocentesis ii. Chorionic Villi aspiration iii. Fetal biopsy iv. Cordocentesis v. Any other (specify): NOT APPLICABLE

22. Any complication/s of invasive procedure (specify) NOT APPLICABLE

23. Additional tests recommended (Please mention if applicable): NOT APPLICABLE

(i) Chromosomal studies (ii) Biochemical studies (iii) Molecular studies (iv) Pre-implantation gender diagnosis (v) Any other (specify): NOT APPLICABLE

24. Result of the Procedures/Tests carried out (report in brief of the invasive tests/procedures carried out): NOT APPLICABLE

25. Date on which procedures carried out: NOT APPLICABLE

26. The result of pre-natal diagnostic procedures was conveyed to: NOT APPLICABLE

27. Any indication for MTP as per the abnormality detected in the diagnostic procedures/Tests: NOT APPLICABLE

Date: NOT APPLICABLE

Place: NOT APPLICABLE

**Section D: Declaration**

**गर्भवतीचेसंमतीपत्र / DECLARATION OF PREGNANT WOMAN**

मी, सौ. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (गर्भवतीचेनाव)

I, Mrs. **(**Name of pregnant woman)

declare that by undergoing ultrasonography/Image scanning. I do not want to know the sex of my foetus.

मी असे नमूद करते की, सदर सोनोग्राफी, तपासणीद्वारे मला गर्भलिंग जाणून घ्यावयाची ईच्छा नाही.

Date: / / Signature/Thumb

दिनांक: गर्भवतीचे सही / अंगठा

Place: Chandannagar, Pune.

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 DOCTOR / PERSON CONDUCTING ULTRASONOGRAPHY / IMAGE SCANNING**

**Dr. SanjivJadhav** (name of the person conducting ultrasonography/image scanning) declare that while conducting ultrasonography/image scanning on Mrs. …………………………………………………………………………….. (name of the pregnant woman) I have neither detected nor disclosed the sex of her fetus in any manner.

Place: Chandannagar, Pune.

Date**: / /** Signature: