FORM F
[Refer proviso to section 4(3) rules 9(4) and 10(1A)]

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

Section A:To be filled in for all Diagnostic Procedure Tests

1. Name and complete address of the Genetic Clinic/Ultrasound Clinic/Imaging Centre:……

2. Registration no. (Under PC & PNDT Act, 1994)……..

3. Patient's Name ……..

4. Total Number of living Children…….

A. Number of living Songs with age of each living son (in years or months)……
……

B. Number of living Daughter with age of each living daughter (in year months)

5. Husband's/wife/Father's/Mother' Name"……

6. Full Postal address of the patient with contact Number, if any……

7. a. Referred by (Full name and addresses of doctor (s)/Genetic Counseling Centre……..

(Referral Slips to be preserved carefully with form F)

b. Self-Referral by Gynecologist/Radiologist/Registered Medical Practitioner Conducting the diagnostic procedure:……..

(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 women)

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 the doctor performing the procedure/s:……

10. Indication/s for diagnosis procedures …….. (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 "Tick" against the appropriate indication/s for ultrasound).

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 of 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 adenexal or uterine pathology/abnormality

1. Substituted vide GSR 109(E), dt. 14-2-2003, w.e.f. 14-2-2003

x. Detection of chromosomal abnormalities, fetal structural defects and other abnormalities and their follow-up
xi. To evaluated fetal presentation and position
xii. Assessment of liquor amnii xiii. Preterm labor/preterm premature rupture of membranes
xiv.Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retro placenta hemorrhage, abnormal adherence etc.)
xv. Evaluation of umbilical cord – presentation, insertion, nuchal encirclement, number of vessels and presence of true knot
xvi. Evaluation of previous Caesarean Section scars
xvii. Evaluation of fetal growth parameters, 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 etc. And their follow-up
xx. Adjunct diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVS) amniocenteses, fetal blood sampling, fetal skin biopsy, amnioinfusion, intrauterine infusion, placement of shunts etc.
xxi. Observation of intra-partum events xxii. Medical/surgical condition complicating pregnancy
xxiii. Research/scientists studies in recognized institutions

11. Procedure carried out (Non-Invasive) Put a “Tick” on the appropriate procedures)

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, Hemophilia A&B etc.)

ii. Any other (specify)

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

13. Date on which procedure carried out:……..

14. Result of the non-invasive procedure carried out (report in brief of the test……
……

15. The result of pre-natal diagnostic procedures was conveyed to……. On
……

16. Any indication for MTP as per the abnormality detected in the diagnostic procedures/ test…….

Date:

Place:

Name, Signature and Registration Numbers with seal of the Gynaecologist/Radiologist/Registered Medical Practitioner performing Diagnostic procedure/s

Section C: To be filled for performing invasive Procedure/Test only

17. Name of the doctor/s performing the procedure/s : ……

18. History of genetic/medical disease in the family
(specify)……

(a) Clinical (b) Bio-chemical

(c) Cytogenetic (d) Other (e.g. radiological, ultrasonography etc. Specify

19. Indication for the diagnosis procedure (“Tick” on appropriate indication)

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. Any other (specify)

B. Advanced maternal age (35)

C. Mother/Father/sibling has genetic (specify)

D. Other (specify)

20. Date on which consent of pregnant women/person was obtained if form G prescribed in PC & PNDT Act, 1994: ……..

21. Invasive procedure carried out (“Tick” on appropriate indication/s)

i. Chromosomal studies

ii. Biochemical studies

iii. Molecular Studies

iv. Pre-implantation gender diagnosis

v. Any other (specify)

22. Any complication/s of invasive procedure (specify)……

23. Additional test 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/Test carried out (report in brief of the invasive

25. Date on which procedure carried out:……

26. The result of pre-natal diagnosis procedure was conveyed to ……

27. Any indication for MTP as per the abnormality detected in the diagnostic procedures tests……

Date :

Place:

Name, Signature and Registration Number with Seal of the Gynecologist/ Radiologist/ Registered Medical Practitioner performing Diagnostic Procedure/s

Section D: Declaration
Declaration of the person undergoing prenatal diagnostic test/Procedure

I, Mrs./Mr. …… declare that by undergoing …… Prenatal Diagnostic Test/Procedure. I do not want to know the sex of my foetus.

Date:

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 and Contact No: ……
……..
Signature of person attesting thumb impression……. Date: ……

Declaration of Doctor/Person Conducting
Pre Natal Diagnostic Procedure/Test

I,……. (name of the person conducting ultrasonography/image scanning) declare that while conducting ultrasonography/image scanning on M/s./ Mr. ……. (name of the pregnant women or the person undergoing per natal diagnostic procedure/test), I have neither detected nor disclosed the sex of her fetus to anybody in any manner.

Signature……
……

Date :

Name in Capitals, Registration Number with Seal of the
Gynaecologist/Radiologist/Registration Medical Practitioner
Conducting Diagnostic procedure