

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:  
\_\_\_\_\_  
\_\_\_\_\_
2. Registration No(Under PC & PNDT ACT, 1994) \_\_\_\_\_
3. Patient's Name \_\_\_\_\_ Age \_\_\_\_\_
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 living daughter (in years of months): \_\_\_\_\_
5. Husband's /wife's /Father's /Mother's Name : \_\_\_\_\_
6. Full postal address of the patient's with Contact Number, if any \_\_\_\_\_
7. (a) Referred by ( Full Name and address of Doctor(s) /Genetic counselling Centre) : \_\_\_\_\_

(Referral slips to be preserved carefully with Form F)

- (b) **Self-Referral** by Gynaecologist/Radiologist/Registered Medical Practitioner conducting the diagnostic procedures: \_\_\_\_\_  
(Referral note with indications case papers of the patients to be preserved with Form F)  
**(Self-referral does not mean a client coming to a clinic and requesting for the test or the relatives requesting for the test of pregnant woman)**
8. Last menstrual period /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 procedure \_\_\_\_\_  
(specify with reference to the request made in the referral slip or in a self-referral note)  
(Ultrasonography parental diagnosis during pregnancy should only be performed when indicated. The following is the representative list of indication 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
  - ii. Estimation of gestational age (dating).
  - iii. Detection of number of fetuses and their chorionicity.
  - iv. Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure/MTP
  - 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.
  - 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 amniixiii.
  - xiii Preterm labor / preterm premature rupture of membranes.
  - xiv. Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retro placental 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 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.
  - 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) (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, Hemophilia A & B etc.)**

- ii. Any other (specify) \_\_\_\_\_
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) \_\_\_\_\_
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/tests \_\_\_\_\_

**SECTION C: To be filled for performing invasive Procedures/ Tests only**

17. Name of the doctor/s performing the procedure/s: \_\_\_\_\_
18. History of genetic/medical disease in the family (specify): \_\_\_\_\_  
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 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 years)
  - C. Mother/father/sibling has genetic disease (specify)
  - D. Other (specify) \_\_\_\_\_
20. Date on which consent of pregnant woman / person was obtained 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/s 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 tests/ procedures carried out) \_\_\_\_\_
25. Date on which procedures carried out: \_\_\_\_\_
26. The result of pre-natal diagnostic procedures was conveyed to \_\_\_\_\_ on \_\_\_\_\_
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 Gynaecologist/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 & Contact No.: \_\_\_\_\_

Signature of a person attesting thumb impression: \_\_\_\_\_ Date: \_\_\_\_\_

**DECLARATION OF DOCTOR/ PERSON CONDUCTING  
PRE NATAL DIAGNOSTIC PROCEDURE/TEST**

I, \_\_\_\_\_ (name of the person conducting ultrasonography / image scanning) declares that the while conducting ultrasonography /image scanning on Ms/Mr \_\_\_\_\_ (name of the pregnant woman or the person undergoing pre natal diagnostic procedure/test), I have neither detected nor disclosed the sex of her foetus to anybody in any manner.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

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

**Date:** \_\_\_\_\_ **Name, Sign and Registration Number with Seal of the Gynaecologist**  
**Place:** \_\_\_\_\_ **/Radiologist /Registered Medical Practitioner performing Diagnostic Procedure/s.**