## 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:

## VARDAAN DIAGNOSTICS,

538 Ka/169 Welcome House, Mausam Bagh Colony, Ahibaranpur, Sitapur Road, Lucknow

2.	Registration No. (Under PC& PNDTAct, 1994): PNDT/AUTH/457/2013			
3.	Patient's nameAge			
	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 or months):			
5.	Husband's /Wife's/ Father's / Mother's Name :			
6.	Full postal address of the patient with Contact Number, if any			
7	(a) Referred by (Full name and address of Dector(a)/ Constitution Counceling Controls			
٠. ا	(a) Referred by (Full name and address of Doctor(s)/ Genetic Counseling 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 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 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 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. 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 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. 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 annii. 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 patheters, 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 shur, is etc. xxi. Observation of intra-partum events. xxiii. 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)			
	. 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 toon			
16	Any indication for MTP as per the abnormality detected in the diagnostic procedures/ tests			
	Place:			

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

17. Name of the doctor's performing the procedure/s.  18. History of genetic/medical disease in the family (specify):  (a) Cinical (b) Bio-chemical (c) Cytogenetic (d) other (e.g. radiological, ultrasonography etcspecify)  19. Indication's for the diagnosis procedure (Tick' on appropriate indication/s):  A. Previous childchildren with:  (i) Chromosomal disorders (ii) Metabolic disorders (iii) Congenital anomaly (iv) Mental Disability (v) Haemoglobinopath (vi) Sex linked disorders (viii) Service (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&PNDTAct, 1994:  21. Invasive procedures carried out ("Tick" on appropriate indication/s)  I. Amniocentesia 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 Procadures/ 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-netal diagnostic procedures was conveyed to	SECTION C. To be filled for performing in		
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I, Mrs./Mr	والمساور	<b>DECLARATION OF THE PERSON UNDERGOING</b>	
Prenatal Diagnostic Test/ Procedure. I do not want to know the sex of my foetus.  Date: Signature/Thump impression of the person undergoing the Prenatal Diagnostic Test/ Procedure  In Case of thumb Impression:  Identified by (Name)		PRENATAL DIAGNOSTIC TEST/ PROCEDURE	
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Relation (if any):Address & Contact No.:		Age:	Sex:
Signature of a person attesting thumb impression:			
DECLARATION OF DOCTOR/PERSON CONDUCTING PRE NATAL DIAGNOSTIC PROCEDURE/TEST  I,		n and a state of the state of t	
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Name in Capitals, Registration Number with Seal of the Gynaecologist /Radiologist/Registered Medical Practitioner Conducting Diagnostic procedure [F No. V.11011/6/2013-PNDT]