

[Form F]

[See Provison 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/Test			
1. Name and address of Genetic Clinic/Ultrasound Clinic/ Imaging Centre			
Name :	JASLOK HOSPITAL AND RESEARCH CENTRE		
Address :	15,DR.G.DESHMUKH MARG		
District:	Not Applicable	Tehsil :	Not Applicable
Village:	0	Pincode:	400026
Telephone:	0 0	Mobile:	9833655671
2. Clinic Registration No :	BMC/PHD 45/MOHD		
3. Patient Name	testannukumari testsanjay mishra		
Patient Age	45		
4.a. Number of living sons with age of each living son	0		
4.b. Number of living Daughters with age of each living Daughter	0		
5. Husband's/Wife's/Father's/Mother's Name	testsanjay mishra		
6. Full postal address of patient	683 sukhani associate co op hsg ltd bombay		
Contact Number	8871203943		
7.(a) Referred By	Referred by		
Name of Doctor Referred by	DR ARPITA CHAKRABORTY		
Name of Centre	BOMBAY HOSPITAL & RESEARCH CENTRE		
Address of Doctor(s)/Genetic counseling centre	12, MARINE LINES, 1ST FLOOR, MRC BUILDING, ROOM NO.106, MUMBAI: 400020.		
8. Last menstrual period or weeks of pregnancy	Date: 12/11/2021 Weeks: 19		
Test to be conducted	Invasive		
Section B : To be filled in for performing non-invasive diagnostic Procedures/Test only(FIELDS ARE TO BE KEPT BLANK AND SIGNATURE IS NOT REQUIRED IF NON-INVASIVE PROCEDURE IS NOT DONE)			
9. Name of the Doctor performing procedures			
10. Indication/s for diagnosis procedure			
11. Procedure carried out(Non-Invasive)			
Other Reason			
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 carried out			
15. The result of pre-natal diagnostic procedures was conveyed to		Date	
Date:			
Place :	Name, Signature and Registration Number With seal of the Gynaecologist/ Radiologist/Registered Medical Practitioner performing Diagnostics Procedure/s		
Section C : To be filled for performing invasive Procedure/Test only			
17. Name of doctor/s performing procedure/s	DR POOJA VYAS		
18. History of genetic/medical disease in the family(specify)Basis of dignosis	<input type="checkbox"/> Bio-Chemical <input type="checkbox"/> Clinical <input type="checkbox"/> Cytogenetic <input type="checkbox"/> Other <input checked="" type="checkbox"/> Not Applicable		
19. Indication/s for the diagnosis procedure	<input type="checkbox"/> Chromosomal Disorders		

A)Previous child/children with	<input type="checkbox"/> Congenital anomaly <input type="checkbox"/> Haemoglobinopathy <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Mental Disability <input type="checkbox"/> Sex linked disorders <input type="checkbox"/> Single Gene Disorder <input checked="" type="checkbox"/> Other <input type="checkbox"/> Not Applicable <input type="checkbox"/> Not Known
19.a. Any Other child Disorder	INCREASE RISK OF TRISOMY 21 ON COMBINED TEST1.5
Advanced maternal Age(35)	Yes
Mother/father/sibling has genetic disease (specify)	No
20. Date on which consent of pregnant woman / person was obtained in Form G prescribed in PC&PNDT Act,1994	21/03/2022
21. Invasive procedures carried out	<input checked="" type="checkbox"/> Amniocentesis <input type="checkbox"/> Chorionic Villi Aspiration <input type="checkbox"/> Cordocentesis <input type="checkbox"/> Foetal Biopsy <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable
22. Any complication/s of invasive procedure(specify)	No
23. Additional tests recommended(please mention if applicable)	<input type="checkbox"/> Preimplantation Genetic Diagnosis <input type="checkbox"/> Chromosomal Studies <input type="checkbox"/> Biochemical Studies <input type="checkbox"/> Molecular Studies <input checked="" type="checkbox"/> Other <input type="checkbox"/> Not Applicable
23.(a). Other Additional tests recommended	result awdited
24. Result of procedures/Tests carried out(report in brief of the invasive tests/procedures carriedout)	Result Awaited from Genetic Lab
25. Date on which Invasive procedure carried out	21/03/2022
26. The result of pre-natal diagnostic procedures was conveyed to	Other
Other Name	Result Awaited from Genetic Lab
27. Any indication for MTP as per the abnormality detected in the diagnostic procedures/tests	Not Applicable/No Comments
Date:21/03/2022	Dr Pooja Vyas (2012041000)
Place :Mumbai,Mumbai,Mumbai	Name, Signature and Registration Number With seal of the Gynaecologist/Radiologist/ Registered Medical Practitioner performing Diagnostics Procedure/s

Declaration

Declaration of Person Undergoing Prenatal Diagnostics Test/Procedure

I, **testannukumari testsanjay mishra** असे घोषित करते की अल्ट्रा-सोनोग्राफी/प्रतिमा स्कॅनिंग करून मी माझ्या गर्भाचे लिंग जाणून घेऊ इच्छित नाही. /declare that by undergoing Prenatal Diagnostic Test/ Procedure.I do not want to know the sex of my foetus.

Date: 21/03/2022

गरोदर स्त्रीची सही/अंगठ्याचा ठसा./Signature/Thump 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:	Place:

DECLARATION OF DOCTOR

I, **Dr Pooja Vyas** declare that while conducting ultrasonography/image scanning on **testannukumari testsanjay mishra**

I have neither detected nor disclosed the sex of her foetus to anybody in any manner.

Date: 21/03/2022

Place: Mumbai,Mumbai,Mumbai

Signature:

Dr Pooja Vyas (2012041000)

Name in capitals,Registration no. with seal of
the Gynaecologist/radiologist/registered medical
practitioner conducting diagnostic procedure