# Annex 8

## [1]FORM D

[Refer rules 9(2)]

Maintenance of Records by the Genetic Counseling Centre

1. Name and address of Genetic Counseling Centre.
2. Registration No.
3. Patient's Name
4. Age
5. Husband's/Father Name
6. Full address with Tel. No., if any
7. Referral by (Full name and address of Doctor (s) with registration no. (s) (Referral note to be preserved carefully with case papers)
8. Last menstrual period/weeks of pregnancy
9. History of genetic/medical disease in the family (specify)

   Basis of diagnosis:

   a. Clinical
   b. Bio-chemical
   c. Cytogenetic
   d. Other (e.g. radiological, ultrasonography
10. Indication for pre-natal diagnosis

    A. Previous child/ children with:

       i. Chromosomal disorders
       ii. Metabolic disorders
       iii. Congenital anomaly
       iv. Mental retardation
       v. Haemoglobinopathy
       vi. Sex linked disorders
       vii. Single linked disorders
       viii. Any other (specify)

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

B. Advanced maternal age (35 years or above)

C. Mother/father/sibling having genetic disease (specify)

D. Others (specify)

11. Procedure advised[2]

    i. Ultrasound

    ii. Amniocentesis

    iii. Chorionic villi biopsy

    iv. Foetoscopy

    v. Foetal skin or organ biopsy

    vi. Cordoecntesis

    vii. Any other (specify)

12. Laboratory test to be carried out

    i. Chromosomal studies

    ii. Biochemical studies

    iii. Molecular studies

    iv. Preimplatation genetic diagnosis

13. Result of diagnosis

    If abnormal give details..... Normal/Abnormal

14. Was MTP advised?

15. Name and address of Genetic Clinic* to which patient is referred.

16. Dates of commencement and completion of genetic counseling

Name, Signature and Registration No. of the
Medical Geneticist/Gynaecologist/Paediatrician
administrating Genetic Counseling

Place:

Date:

2. Strike out whichever is not applicable or necessary