FORM D

[See rule 9(2)]

FORM FOR MAINTENANCE OF RECORDS BY THE GENETIC COUNSELLING CENTRE

1.NAME, ADDRESS OF GENETIC COUNSELLING CENTRE

2.REGISTRATION No.

3. Patient's name

4. Age

5.Husband's/Father's name

6. Full address with Tel. No., if any

7. Referred 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 gene disorder
(viii) Any other (specify)

B. Advanced maternal age (35 years)

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

D. Others (specify)

11. Procedure advised[19]

(i) Ultrasound
(ii) Amniocentesis
(iii) Chorionic villi biopsy
(iv) Foetoscopy
(v) Foetal skin or organ biopsy
(vi) Cordocentesis
(vii) Any other (specify)

12.Laboratory tests to be carried out

(i) Chromosomal studies
(ii) Biochemical studies
(iii) Molecular studies
(iv) Preimplantation gender diagnosis

13. Result of pre-natal 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.

Place:
Date:

Name, Signature and Registration No. of the Medical Geneticist/ Gynaecologist/ Paediatrician administering Genetic Counselling.

[19] Strike out whichever is not applicable or necessary.