After Opening page

You will see the following screen. Then enter your PIN.

It will show you Form-A (center registration form)

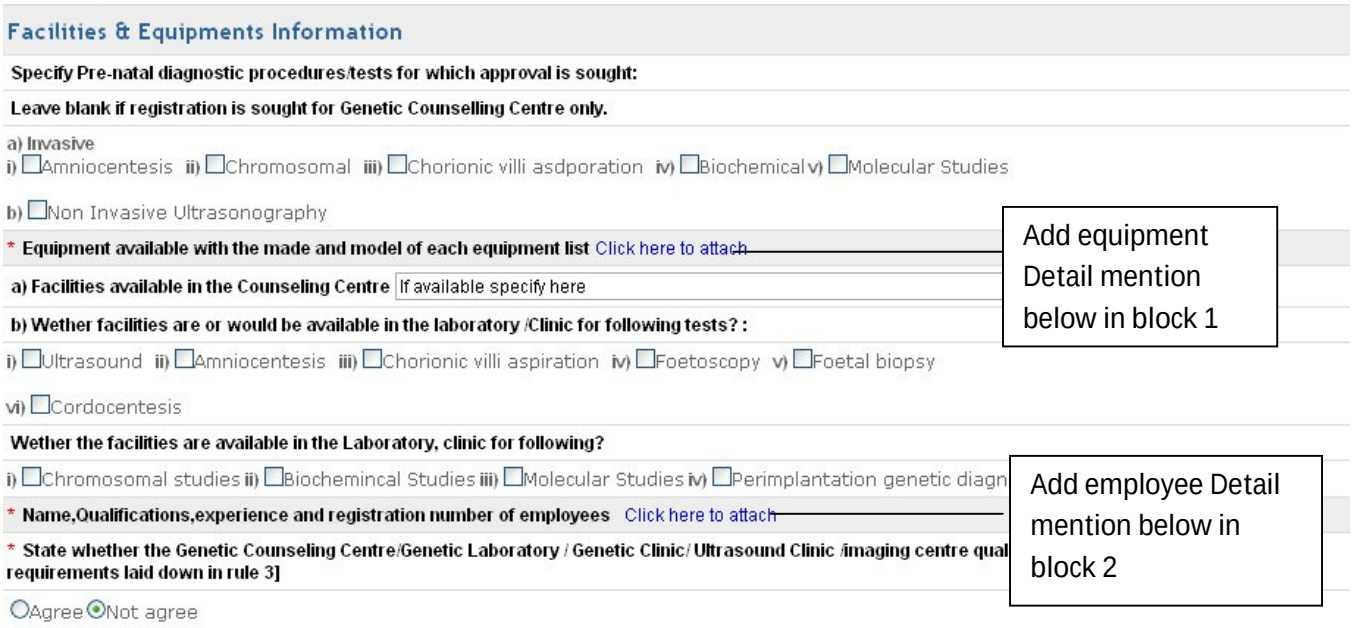
FORM A
[See rules 4(1) and 8(1)]
(To be submitted in Duplicate)
FORM OF APPLICATION FOR REGISTRATION OR RENEWAL OF REGISTRATION OF GENETIC COUNSELING CENTRE/ GENETIC LABORATORY GENETIC CLINIC / ULTRASOUND CLINIC / IMAGING CENTRE.

Owners Information

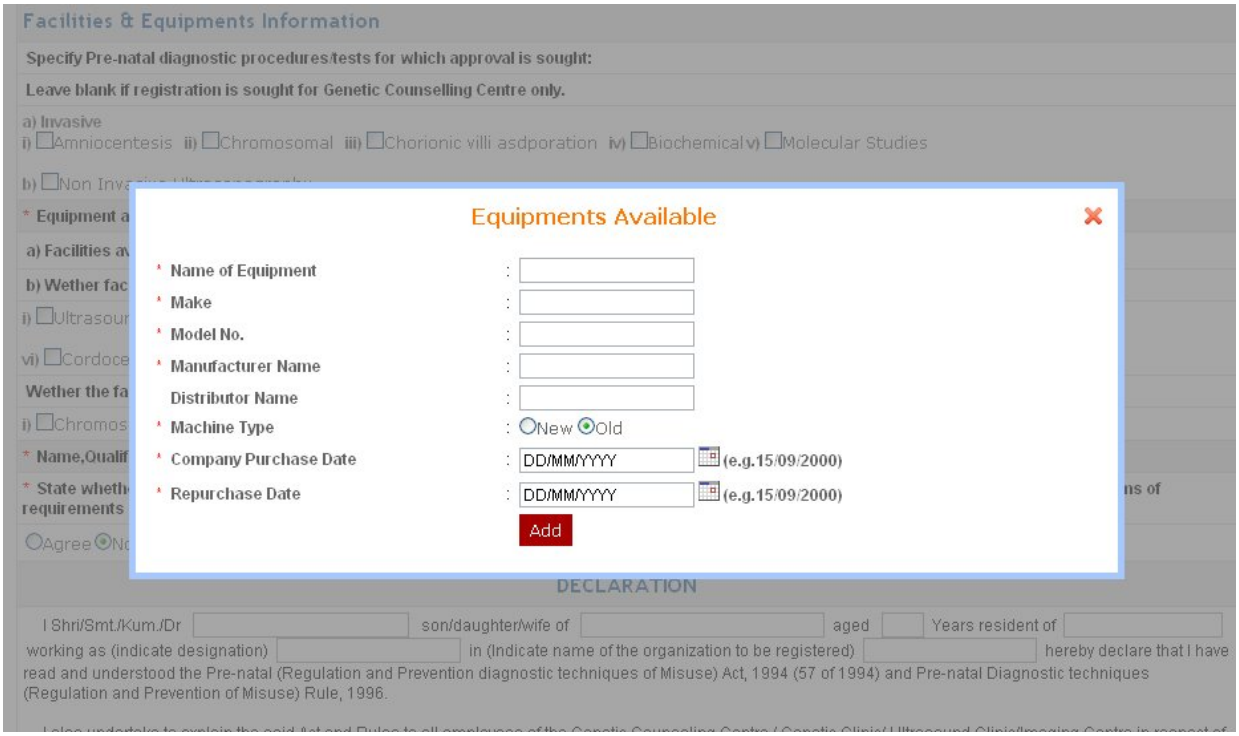
* Name of Applicant	
* Address	
Telephone	(e.g 0231123456)
Fax	(e.g 0231123456)
Mobile	(e.g 999999999)
* Email	(e.g admin@savethebabygirl.com)

Centre Information

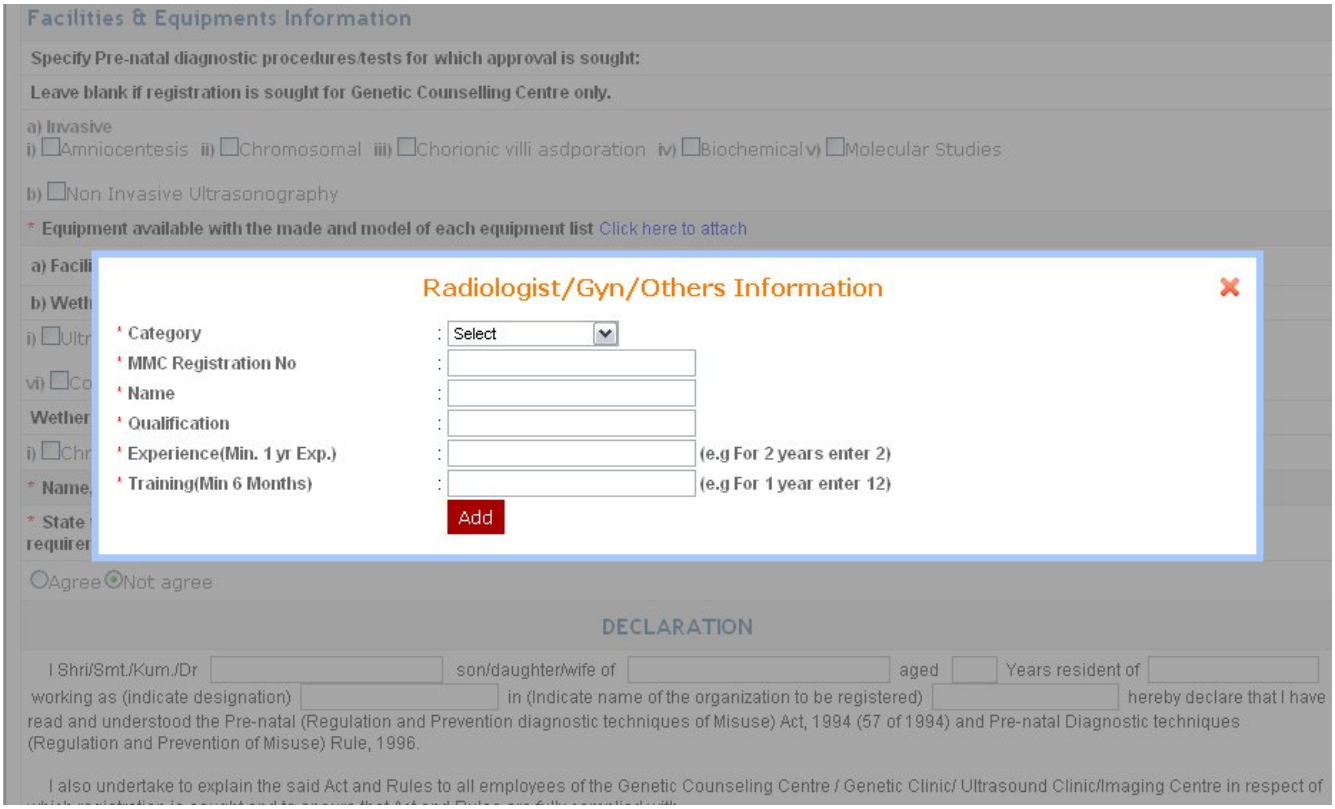
* PNDT Centre Registration No	
* Date of Issue	DD/MM/YYYY (e.g.15/09/2000)
Facility to Registered	i) ☐Genetic Counseling Centre ii) ☐Genetic Laboratory iii) ☐Genetic Clinic iv) ☐Imaging Centre v) ☐Ultrasound Clinic
* Name of Centre	
* Address	
Telephone	(e.g 0231123456)
Fax	(e.g 0231123456)
* Mobile	(e.g 999999999)
* Email	(e.g admin@savethebabygirl.com)
Type of Ownership	○Individual ○Partnership ○Co-Operative ○Company ○Other If other specify here
* Type of Institution	select

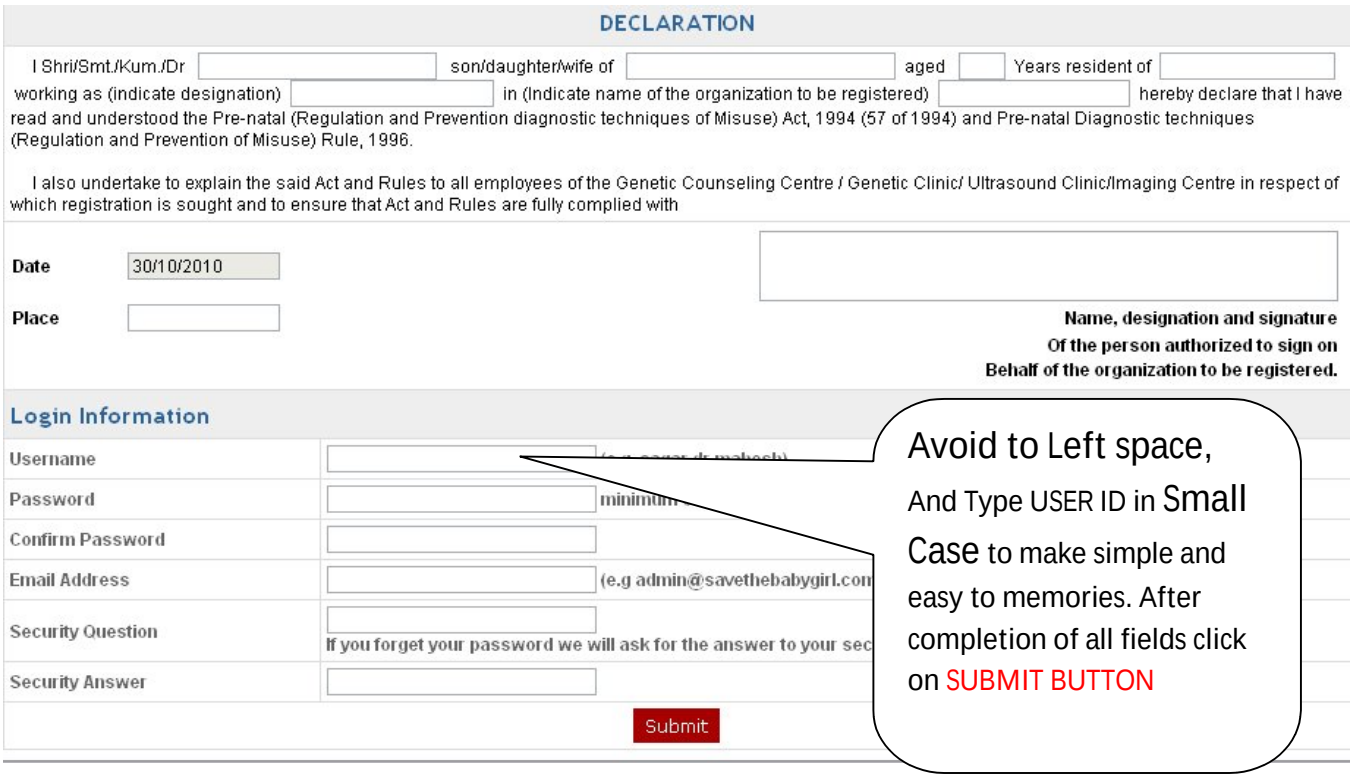


[BLOCK 1] After click on this link you will see this form to add equipment detail



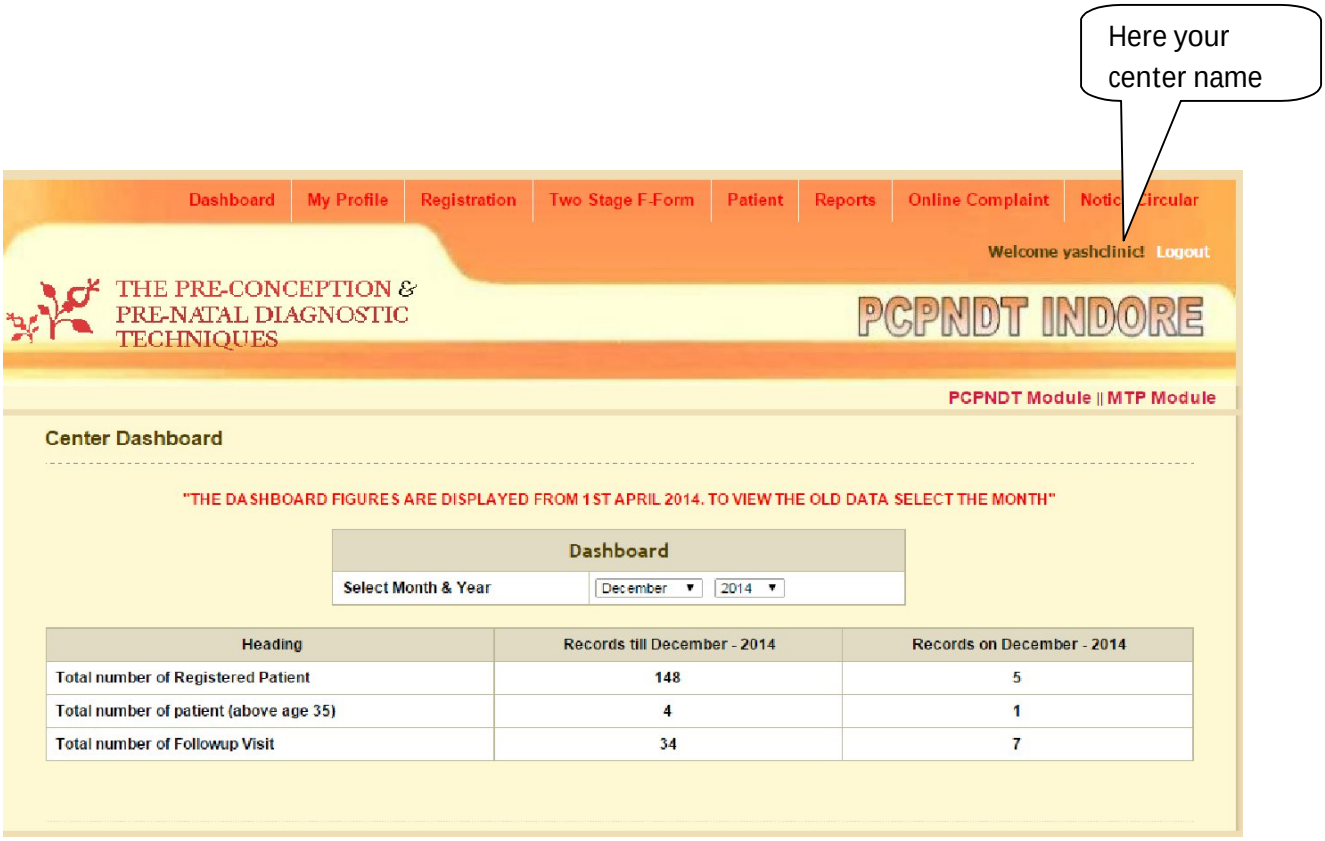
[BLOCK 2] After click on this link you will see this form to add employee detail



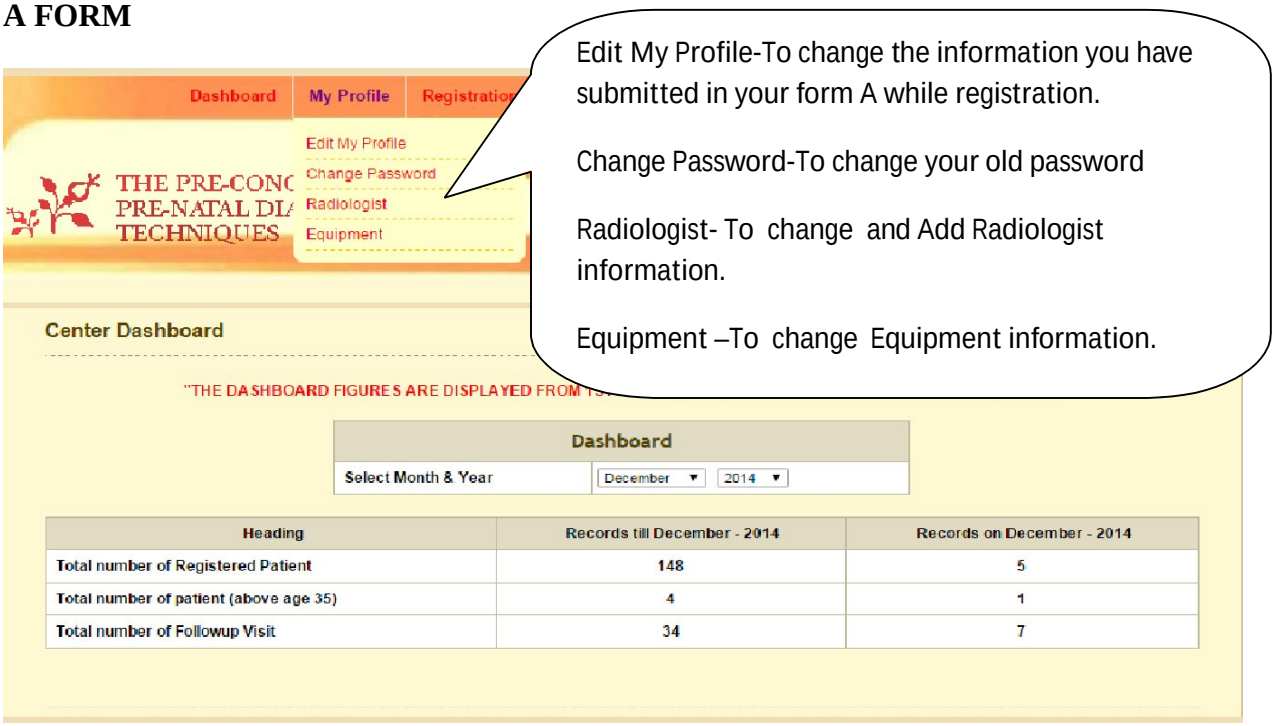


Here you will create your username and password. Once you do successfully centre registration, you can use username and password to Login in to the website.

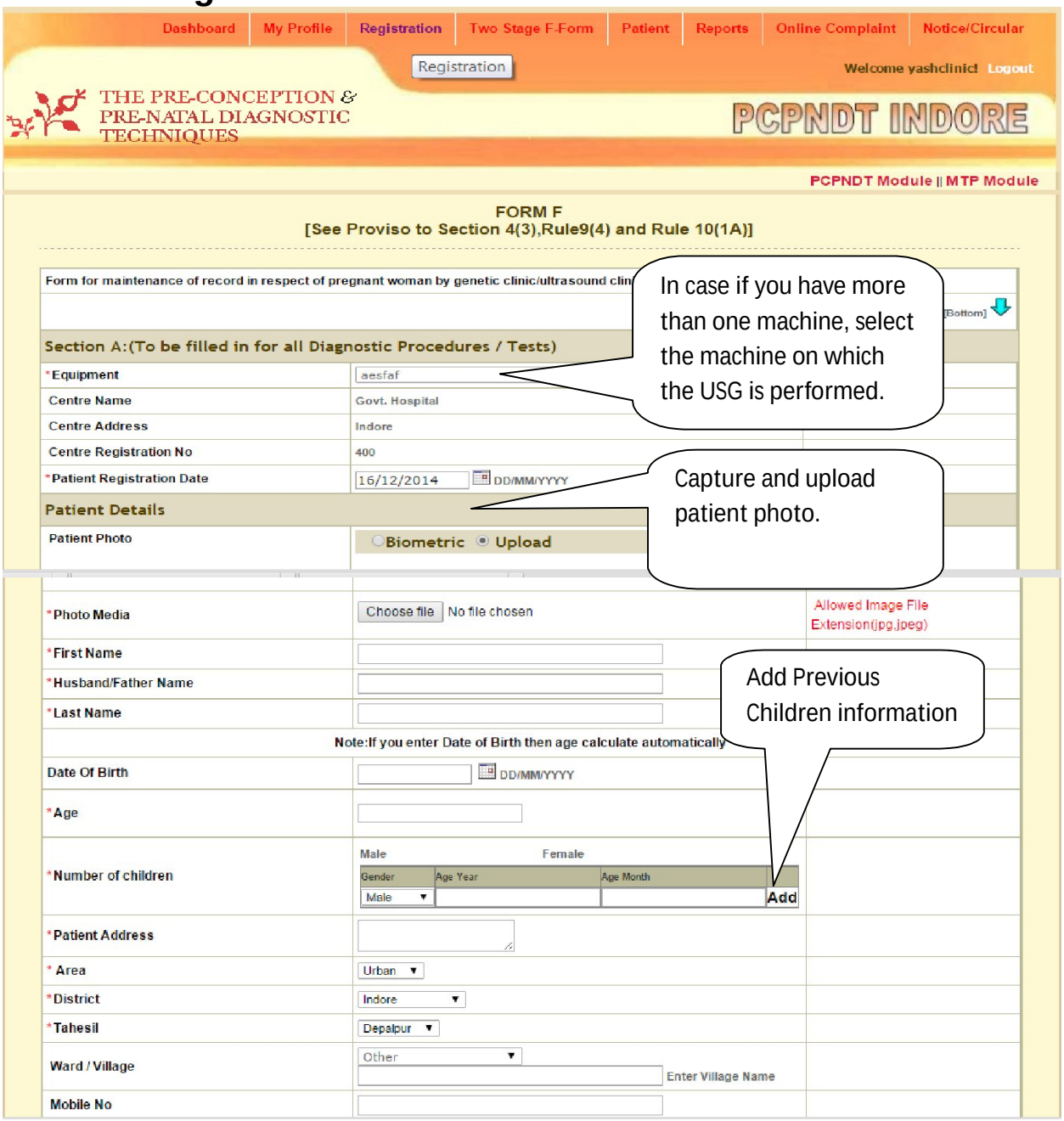
Once you login with your user name and password you can able to access site And this is your Dashboard/first page



IF REQUIRED TO EDIT /CHANE PROFILE YOU CAN EDIT HERE AS BELOW IN A FORM



F- Form Registration



Email		
Telephone No		

*Referred By	Doctor Genetic Counselling Centre Self Referral	
*Referred Doctor Name	Other	
*Doctor Address		
*Referal Note:		

Last Menstrual Period	DD/MM/YYYY	Not Known
Weeks of Pregnancy	0	

Section B: To be filled in for performing Non-Invasive diagnostic Procedures/ Tests only

Procedures carried out by	Radiologist Gynecologist Directors Of Clinic Registered Medical Practi Others Name Select Registration No
Non-Invansive Procedures carried out	(i)Ultrasound (ii)Any Other (specify)

Select Doctor Name

Reprentative list of Indications for Ultrasound during Pregnancy

1. To diagnose intra-uterine and / or ectopic pregnancy and confirm viability.
2. Estimation of gestational age(dating).
3. Detection of number of foetuses and their chorionicity.
4. Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure / MTP failure.

For Ultrasound please select Indications	Normal Abnormal	
Date on which declaration of pregnant woman/ person was obtained :	16/12/2014 DD/MM/YYYY	
Date(s) on which procedure carried out	16/12/2014 DD/MM/YYYY	
Result of the Non-Invasive Procedure /Test carried out	(Give details)	

The result of pre-natal diagnostic procedure were conveyed to The Patient On 16/12/2014 DD/MM/YYYY

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

Procedures carried out by	Radiologist Gynecologist Directors Of Clinic Registered Medical Practitioner Others Name Select Registration No
History of genetic/medical disease in the family	No — If Yes, then type it in place of No
Basis of diagnosis	(a). Clinical (b). Bio-Chemical (c). Cytogenetic (d). Other
Indication/s for the diagnosis Procedure	
(A) Previous child/children with	(i). Chromosomal disorders (ii). Metabolic Disorder (iii). Cogenital Anomaly (iv). Mental Retardation (v). Haemoglobinopathy (vi). Sex linked Disorders (vii). Single gene disorder (viii). Other
(B) Advanced maternal age(35)	No
(C) Mother/Father/Sibling has genetic disease	No
(D) Other	No

Date on which consent of pregnant woman / person was obtained in Form F prescribed in PC/PNDT Act, 1994	DD/MM/YYYY
Invasive procedures carried out ("Tick" on appropriate indication/s)	(i). Amniocentesis (ii). Chorionic Villi aspiration (iii). Foetal Biopsy (iv). Cordocentesis (v). Other
Any Complication of procedure	Not Applicable
Additional / Laboratory Tests Recommended	(i). Chromosomal studies (ii). Bio-chemical Studies (iii). Molecular Studies (iv). Preimplantation genetic diagnosis (v). Any Other(Specify)
Invasive procedure / Test carried out Result	(Give details)
Date on which Procedure carried Out	DD/MM/YYYY
The result of pre-natal diagnostic procedure were conveyed to	The Patient On DD/MM/YYYY
Any indication for MTP as per the abnormality detected in the diagnostic Procedures / Tests	(If give details)

Identity Proof Details

Id Proof Type	Other
Id Proof Name	
Id Proof No	
Identity Proof Of	Self Husband Father Mother Other
Identity Proof Of Name	

Identity Proof Details

Id Proof Type	Other
Id Proof Name	
Id Proof No	
Identity Proof Of	Self Husband Father Mother Other
Identity Proof Of Name	

Declaration In Case of thumb Impression:

Name Of the Person Indentify by	
Age	
Gender :	Male
Relation if(any)	
Address & Contact No.:	(Give detail

* Date : 16/12/2014 DD/MM/YYYY

* Place : Indore

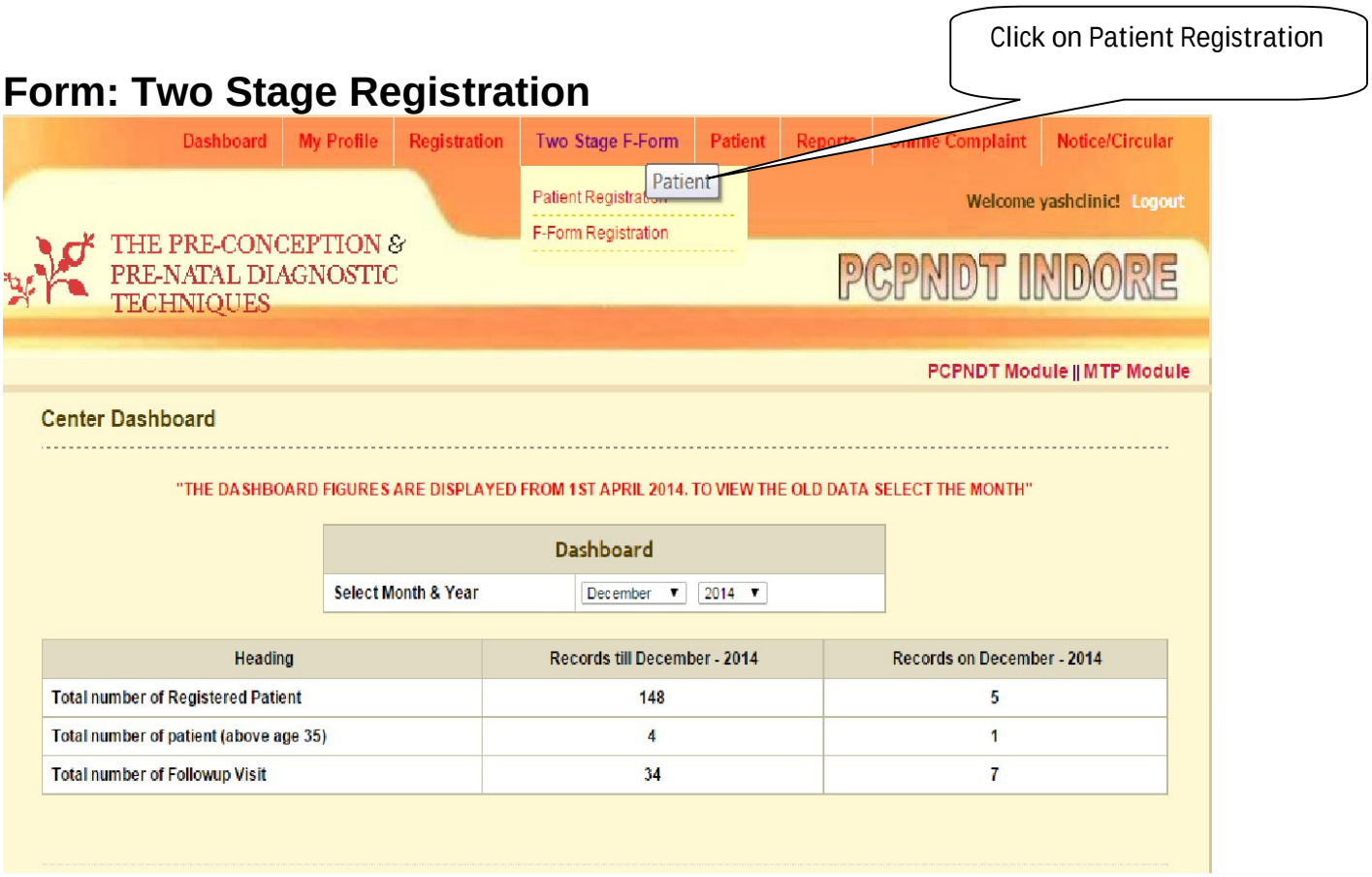
Agree Not Agree

Submit

[Top]

Fill all compulsory Filled then Click Agree button and submit Form.

Form: Two Stage Registration



You will get the following Patient Details form. Fill the details and submit the form.

FORM F
[See Proviso to Section 4(3),Rule9(4) and Rule 10(1A)]

Form for maintenance of record in respect of pregnant woman by genetic clinic/ultrasound clinic/imaging centre

Back [Bottom]

Centre Name	Govt. Hospital	
Centre Address	Indore	
Centre Registration No	400	
*Patient Registration Date	16/12/2014 DD/MM/YYYY	

Patient Name

Patient Photo	Capture Upload	
*Photo Media	Choose file No file chosen	Allowed Image File Extension(jpg,jpeg, bmp)
*First Name	No file chosen	
*Husband/Father Name		
*Last Name		

Note:If you enter Date of Birth then age calculate automatically

Date Of Birth	DD/MM/YYYY	
*Age		

*Age		
*Number of children	Male Female Gender: Male / Age Year / Age Month / Add	
*Patient Address		
* Area	Urban	
*District	Indore	
*Tahesil	Depalpur	
Ward / Village	Other Enter Village Name	
Mobile No		
Email		
Telephone No		

*Referred By	Doctor Genetic Counselling Centre Self Referral	
*Referred Doctor Name	Other	
*Doctor Address		
*Referal Note:		
Last Menstrual Period	DD/MM/YYYY	Not Known
Weeks of Pregnancy	0	

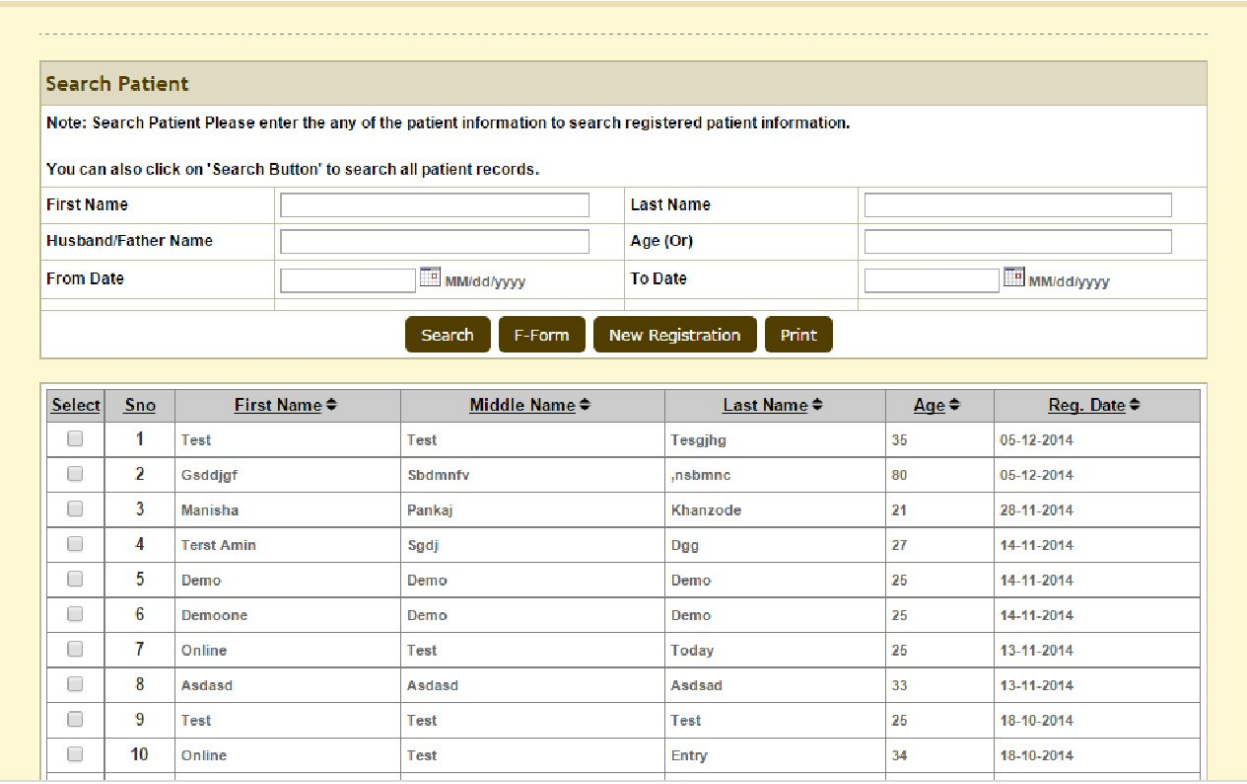
Identity Proof Details

Id Proof Type	Other
Id Proof Name	
Id Proof No	
Identity Proof Of	Self Husband Father Mother Other
Identity Proof Of Name	

Submit

[Top]

You will get the following screen or Click on Registration _ FFormRegn.



Search Patient

Note: Search Patient Please enter the any of the patient information to search registered patient information.

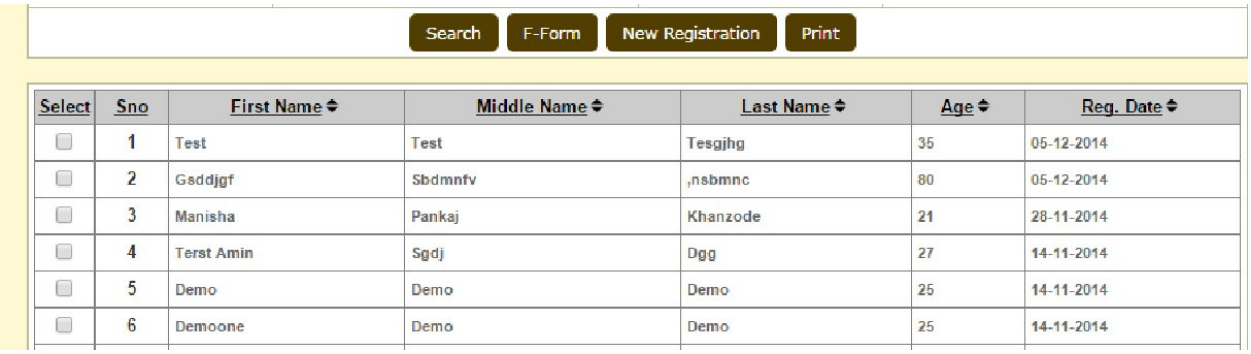
You can also click on 'Search Button' to search all patient records.

First Name		Last Name	
Husband/Father Name		Age (Or)	
From Date	MM/dd/yyyy	To Date	MM/dd/yyyy

Search | F-Form | New Registration | Print

Select	Sno	First Name	Middle Name	Last Name	Age	Reg. Date
	1	Test	Test	Tesgjhg	35	05-12-2014
	2	Gsddjgf	Sbdmnfv	,nsbmnc	80	05-12-2014
	3	Manisha	Pankaj	Khanzode	21	28-11-2014
	4	Terst Amin	Sgdj	Dgg	27	14-11-2014
	5	Demo	Demo	Demo	25	14-11-2014
	6	Demoone	Demo	Demo	25	14-11-2014
	7	Online	Test	Today	25	13-11-2014
	8	Asdasd	Asdasd	Asdsad	33	13-11-2014
	9	Test	Test	Test	25	18-10-2014
	10	Online	Test	Entry	34	18-10-2014

Either search the patient or click the check box of the patient for which you want to fill the F Form and click on the F Form Button above.



Search | F-Form | New Registration | Print

Select	Sno	First Name	Middle Name	Last Name	Age	Reg. Date
	1	Test	Test	Tesgjhg	35	05-12-2014
	2	Gsddjgf	Sbdmnfv	,nsbmnc	80	05-12-2014
	3	Manisha	Pankaj	Khanzode	21	28-11-2014
	4	Terst Amin	Sgdj	Dgg	27	14-11-2014
	5	Demo	Demo	Demo	25	14-11-2014
	6	Demoone	Demo	Demo	25	14-11-2014

You will see the F Form as follows with all details of the patient. Fill the remaining Form and Submit it.

FORM F
[See Proviso to Section 4(3),Rule9(4) and Rule 10(1A)]

Form for maintenance of record in respect of pregnant woman by genetic clinic/ultrasound clinic/imaging centre

Back [Bottom]

*Equipment	aesfaf	
Centre Name	Govt. Hospital	
Centre Address	Indore	
Centre Registration No	400	
*Patient Registration Date	05/12/2014 DD/MM/YYYY	

Patient Name

*First Name	Test	
*Husband/Father Name	Test	
*Last Name	Tesgjhg	
Date Of Birth		
*Age	35	
Number of children	Male 1 Female 0	
	(a) Number of living Sons with age of each living son (in years or months): 1) Age: 3 Yrs. 0 Months	
	(b) Number of living Daughters with age of each living daughter (in years or months) :	
Patient Address	svcxv	
* Area	Urban	
*District	Indore	
*Tahesil	Indore	
Ward / Village	Snehalata Ganj Ward	
Mobile No		
Email		
Telephone No		

*Referred By	Doctor Genetic Counselling Centre Self Referral	
*Referal Note:	xzcvxcv	

Last Menstrual Period		Not Known
Weeks of Pregnancy	0	

Section B: To be filled in for performing Non-Invasive diagnostic Procedures/ Tests only

Procedures carried out by

Radiologist Gynecologist
Directors Of Clinic Registered Medical Practitioner
Others

Name Select

Registration

	No
Non-Invansive Procedures carried out	(i)Ultrasound (ii)Any Other (specify)

12. Assessment of liquor amnii.
13. Preterm labour/preterm premature rupture of membranes.
14. Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence etc.).
15. Evaluation of umbilical cord-presentation, insertion, nuchal encirclement. number of vessels and presence of true knot.
16. Evaluation of previous Caesarean Section scars.
17. Evaluation of foetal growth parameters, foetal weight and foetal well being.
18. Colour flow mapping and duplex Doppler studies.
19. Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc and their follow-up.
20. Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling(CVS), amniocenteses, foetal blood sampling, foetal skin biopsy, amnioinfusion, intrauterine infusion, placement of shunts etc.
21. Observation of intra-partum events.
22. Medical/surgical conditions complicating pregnancy.
23. Research/scientific studies in recognised institutions.

For Ultrasound please select Indications	Normal Abnormal	
Date on which declaration of pregnant woman/ person was obtained :	16/12/2014 DD/MM/YYYY	
Date(s) on which procedure carried out	16/12/2014 DD/MM/YYYY	
Result of the Non-Invasive Procedure /Test carried out	(Give details)	
The result of pre-natal diagnostic procedure were conveyed to	The Patient On 16/12/2014 DD/MM/YYYY	

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

Procedures carried out by	Radiologist Gynecologist Directors Of Clinic Registered Medical Practitioner Others **Name** Select **Registration No**
History of genetic/medical disease in the family	No If Yes, then type it in place of No
Basis of diagnosis	(a). Clinical (b). Bio-Chemical (c). Cytogenetic (d). Other
Indication/s for the diagnosis Procedure	
(A) Previous child/children with	(i). Chromosomal disorders (ii). Metabolic Disorder (iii). Cogenital Anomaly (iv). Mental Retardation (v). Haemoglobinopathy (vi). Sex linked Disorders (vii). Single gene disorder (viii). Other
(B) Advanced maternal age(35)	Yes
(C) Mother/Father/Sibling has genetic disease	No
(D) Other	No
Date on which consent of pregnant woman / person was obtained in Form F prescribed in PC/PNDT Act, 1994	DD/MM/YYYY
Invasive procedures carried out ("Tick" on appropriate indication/s)	(i). Amniocentesis (ii). Chorionic Villi aspiration (iii). Foetal Biopsy (iv). Cordocentesis (v). Other
Any Complication of procedure	Not Applicable
Additional / Laboratory Tests Recommended	(i). Chromosomal studies (ii). Bio-chemical Studies (iii). Molecular Studies (iv). Preimplantation genetic diagnosis

Invasive procedure / Test carried out Result	(Give details)
Date on which Procedure carried Out	DD/MM/YYYY
The result of pre-natal diagnostic procedure were conveyed to	The Patient On DD/MM/YYYY
Any indication for MTP as per the abnormality detected in the diagnostic Procedures / Tests	(If give details)

Declaration In Case of thumb Impression:

Name Of the Person Indentify by	
Age	
Gender :	Male
Relation if(any)	
Address & Contact No.:	(Give details)

* Date : 16/12/2014 DD/MM/YYYY

* Place : Indore

Agree Not agree

Submit

[Top]

Indication for pre-natal diagnosis

Previous child/children with	☐(i). Chromosomal disorders ☐(ii). Metabolic Disorder ☐(iii). Cogenital Anomaly ☐(iv). Mental Retardation ☐(v). Hemoglobinopathy ☐(vi). Sex linked Disorders ☐(vii). Single gene disorder ☐(viii). Other
Advanced maternal age(35)	
Mother/Father/Sibling has genetic disease	(Specify)
Other	(Specify)
***Procedures carried out by**	◉Radiologist ○Gynecologist ○Directors Of Clinic ○Registered Medical Practitioner ○Others ***Name** Select **Registration No**

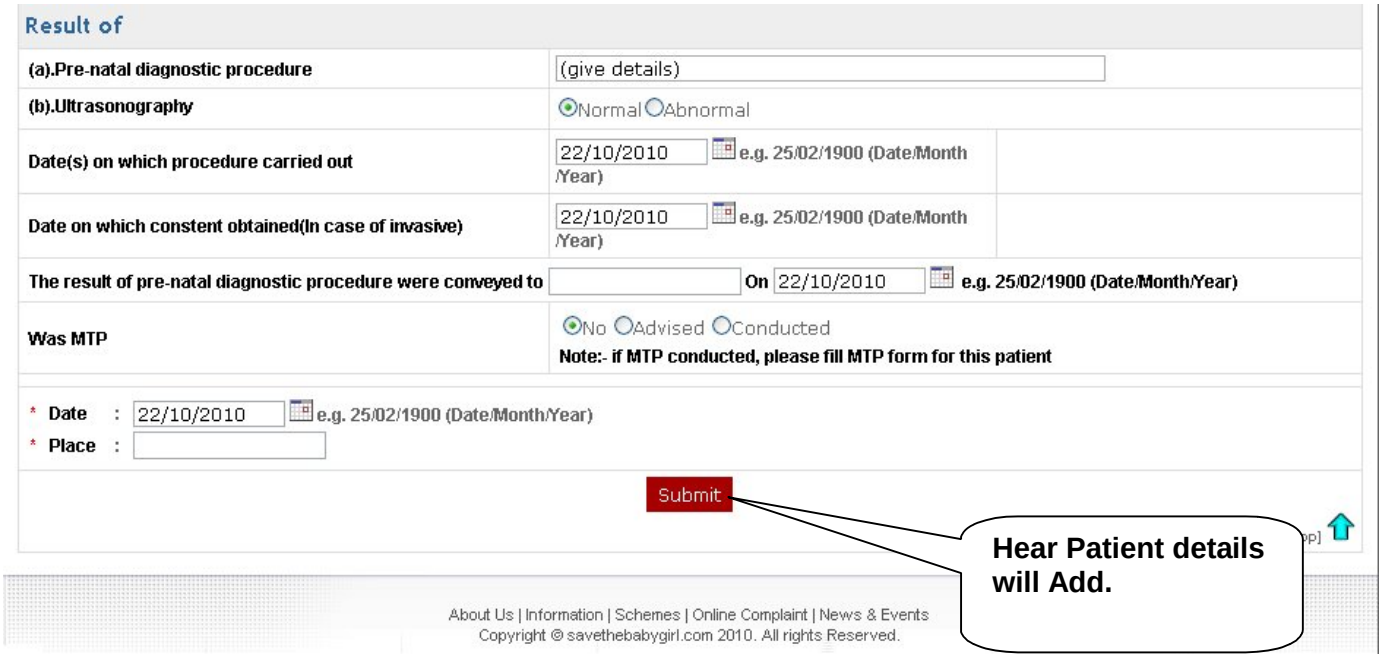
(Note :- Please Select either Invasive or Non-Invasive)

Non - Invasive	☐(i)Ultrasound **(Note :- For Ultrasound please select following indications)**

Reprentative list of Indications for Ultrasound during Pregnancy

☐To diagnose intra-uterine and / or ectopic pregnancy and confirm viability.
☐Estimation of gestational age(dating).
☐Detection of number of foetuses and their chorionicity.
☐Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure / MTP failure.
☐Vaginal bleeding/leaking.
☐Follow-up of cases of abortion.
☐Assessment of cervical canal and diameter of internal os.
☐Discrepancy between uterine size and period of amenorrhea.
☐Any suspected adenexal or uterine pathology/abnormality.
☐Detection of chromosomal abnormalities, foetal structural defects and other abnormalities and their follow-up.
☐To evaluate foetal presentation and position.
☐Assessment of liquor amnii.
☐Preterm labour/preterm premature rupture of membranes.
☐Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence etc.)

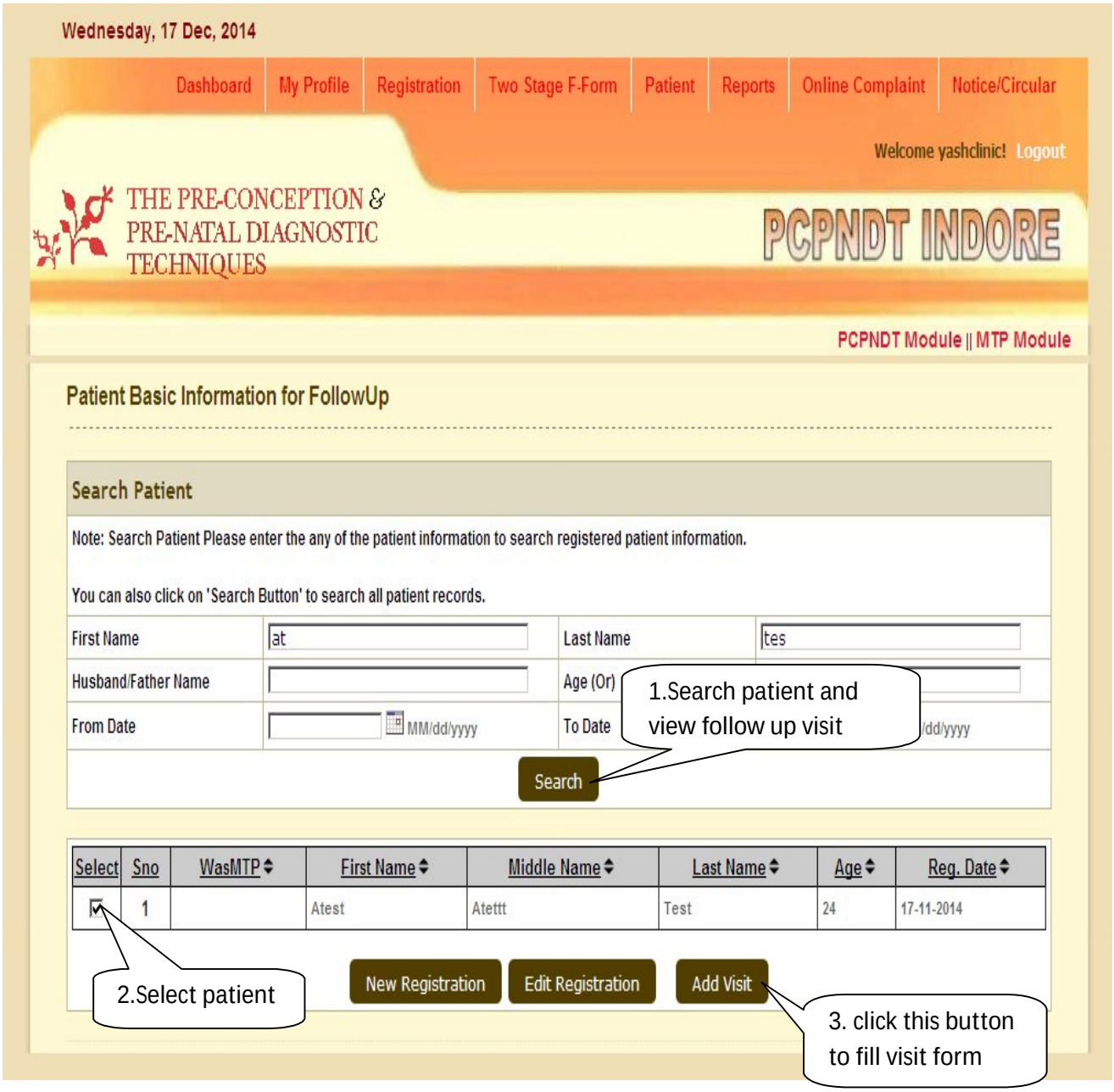
Invasive	☐(i). Amniocentesis ☐(ii). Chorionic Villi aspiration ☐(iii). Foetal Biopsy ☐(iv). Cordocentesis ☐(v). Other
Any Complication of procedure	(Please Specify)
Laboratory Tests Recomended	☐(i). Chromosomal studies ☐(ii). Bio-chemical Studies ☐(iii). Molecular Studies ☐(iv). Preimplantation genetic diagnosis



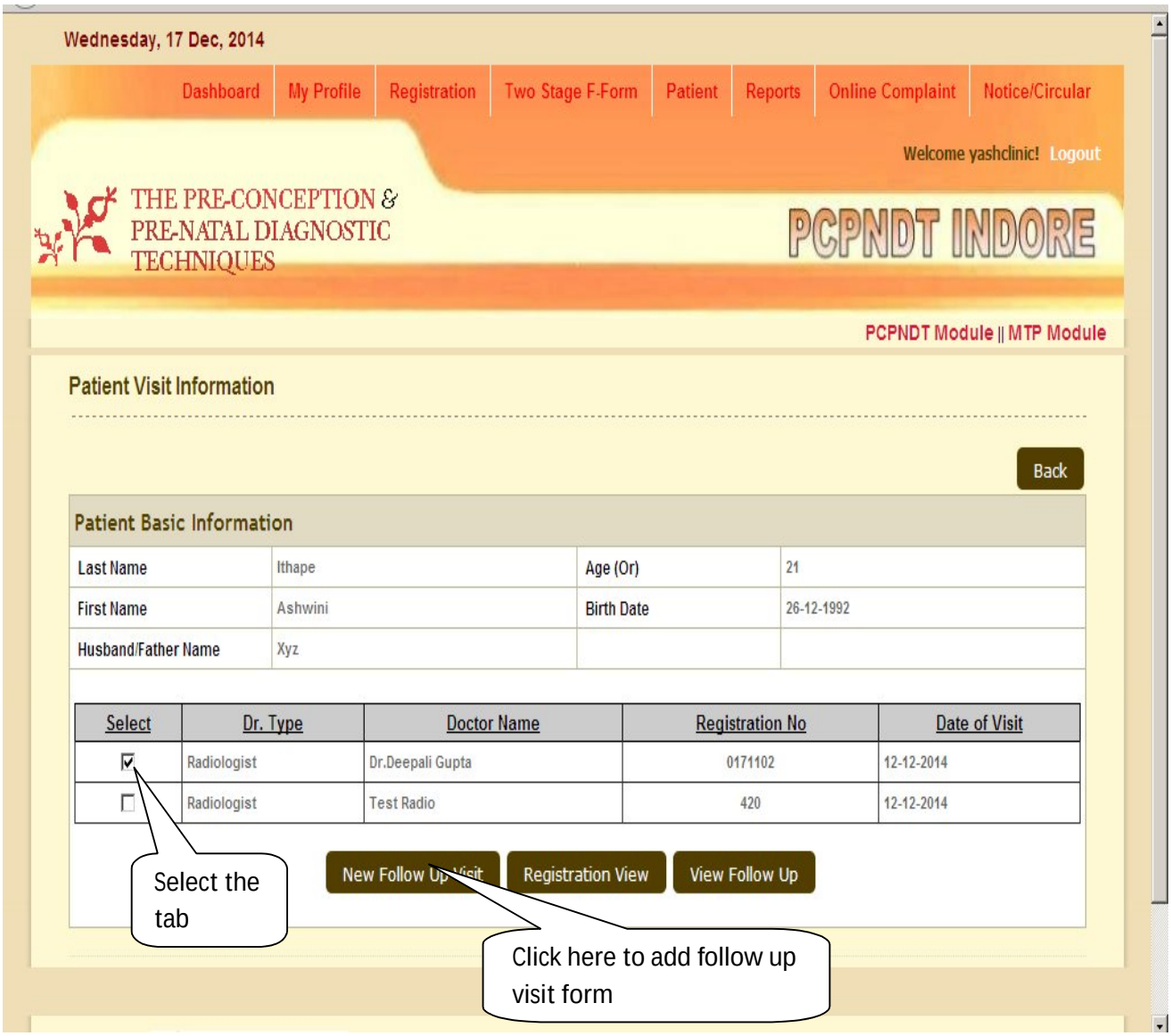
Labels with *marked are compulsory to fill for user

Form: Patient

Follow up visit

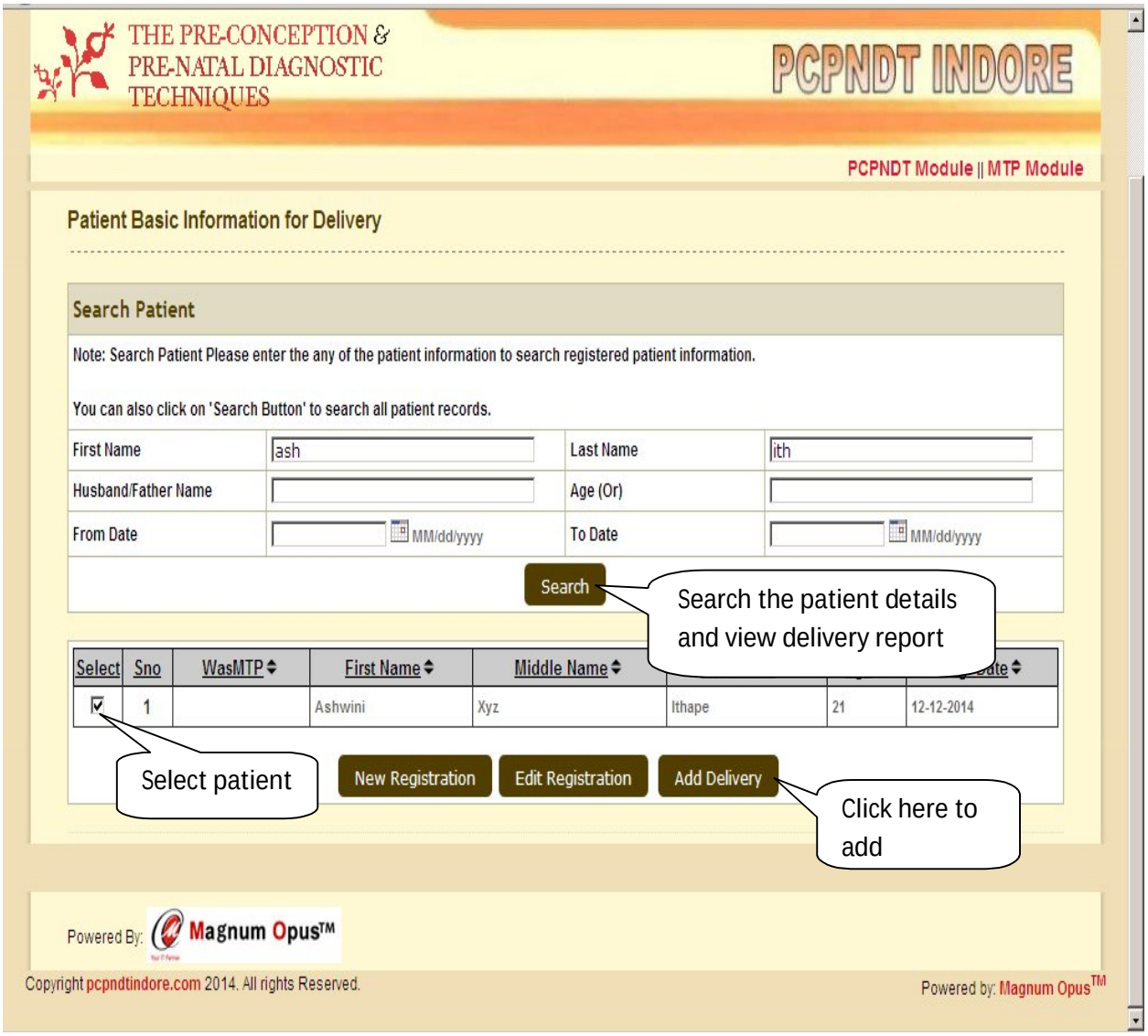


After clicking on Add Visit button following form will open:

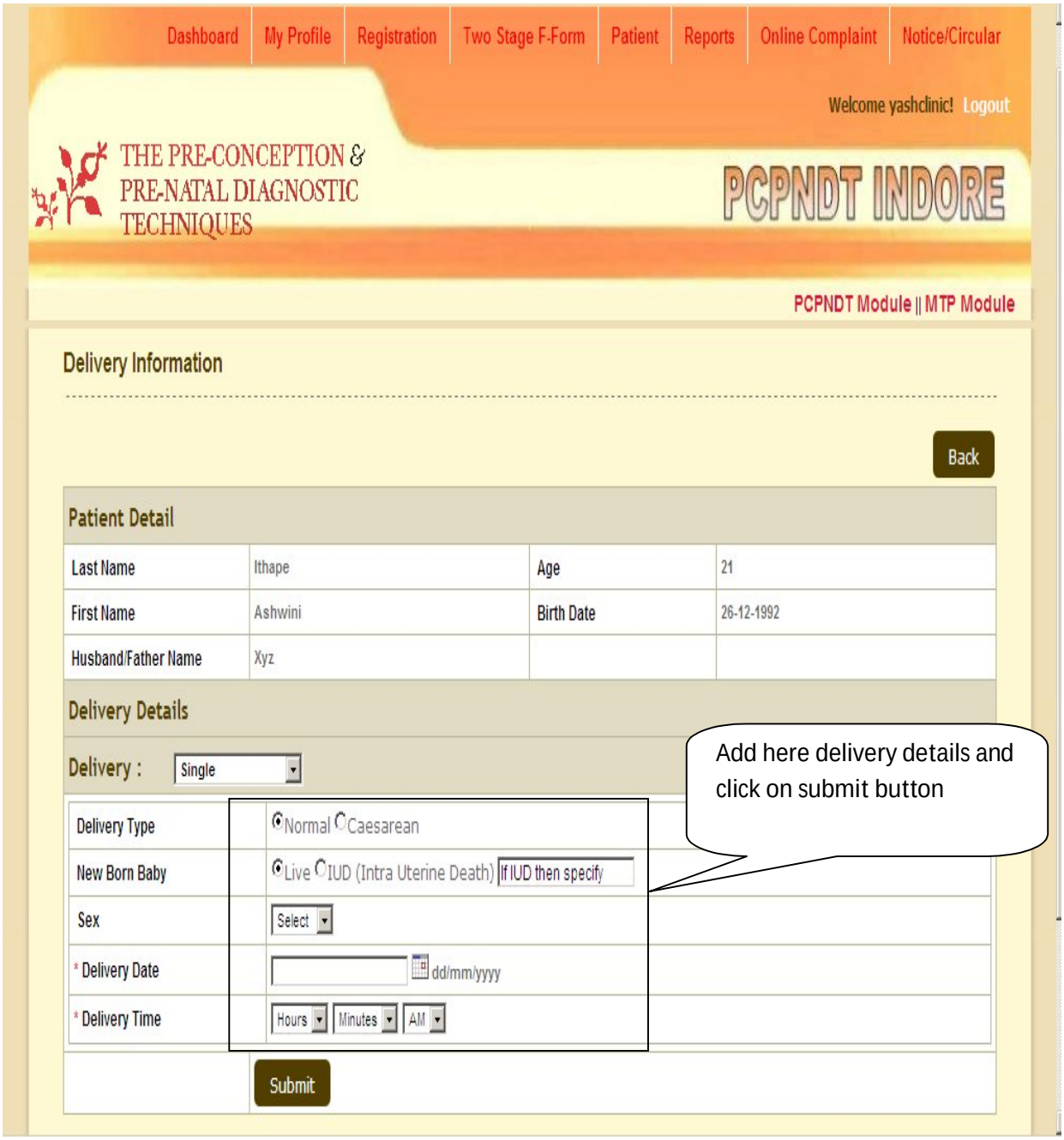


Click on new follow up button to make changes in the form and then submit the form.

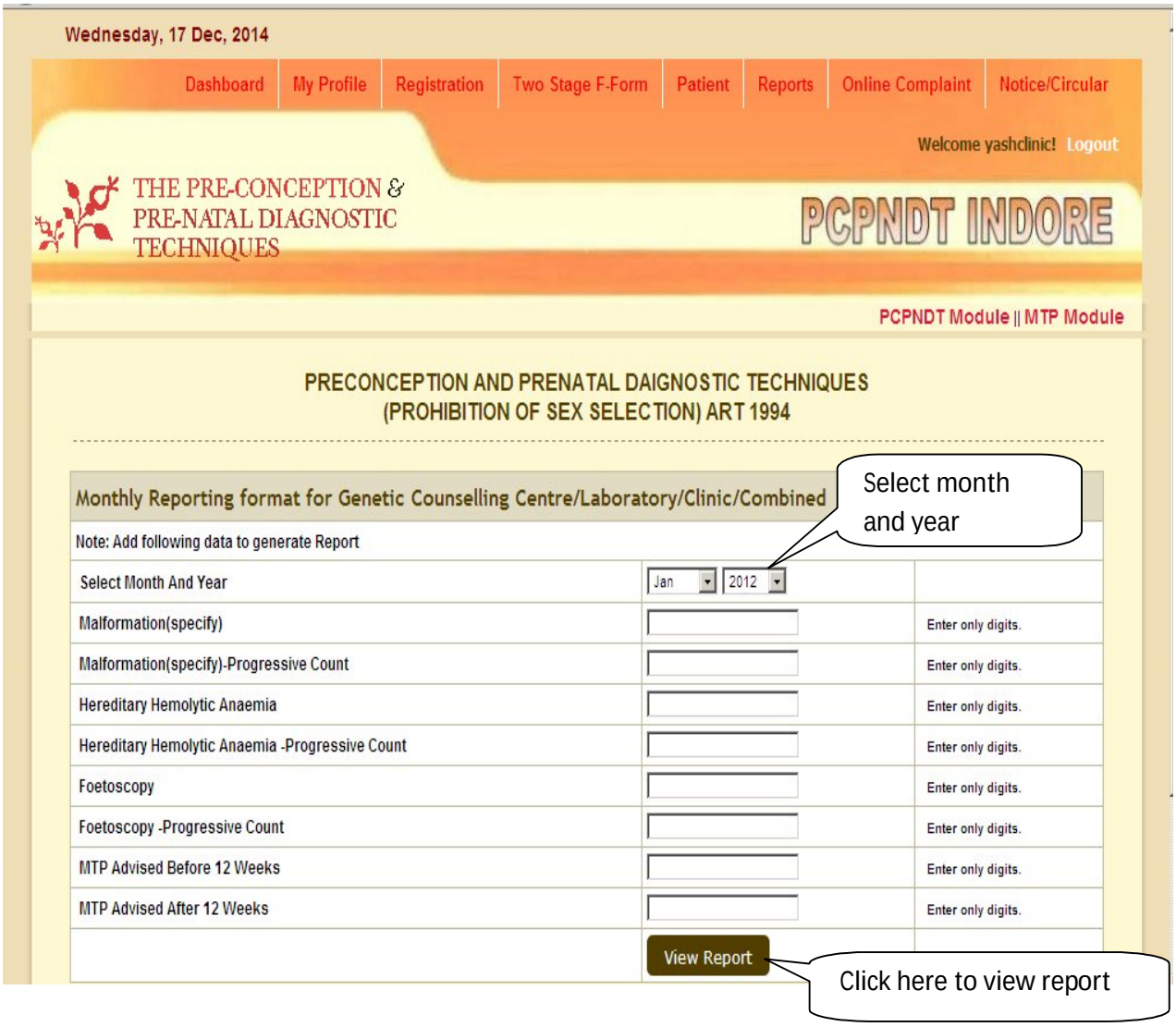
Form: Delivery



After clicking on Add Delivery button following form will open:



Reports:
Monthly Center Report



After clicking on view report button following report page will open:

PRECONCEPTION AND PRENATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION)ART 1994

Monthly Reporting format for Genetic Counselling Centre/Laboratory/Clinic/Combined

Monthly Report For : Nov- 2014

Name of the Genetic Counselling Centre/laboratory/Clinic: Govt. Hospital

Registration No: 400

Name Of Director: Govt. Hospital

1. **Total No.of Patients:** 12

From Madhya Pradesh	12
From Other States	3

2 **Issuewise Break up of the patients**

0 Issue	1	2 or 2+ Males	0
Only 1 Male	6	2 or 2+ Females	0
Only 1 Female	4	Other	1

3 **Age-wise Break up of the patients**

Less then 18 years	0	30-35 Years	1
18-30 years	10	Above 35 years	1

4 **Indication for Prenatal Diagnosis**

Sr.No	Type of Indication	During the Month	Progressive
A	PREVIOUS CHILD WITH		

Online complaint: