

## After Opening page



The image shows the home page of the PCPNDT Indore website. The header features the logo "THE PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES" on the left and navigation links "Center Registration | Online Enquiry | Technical Support" and "News & Events | Photo Gallery | Video Gallery" on the right. The main content area is divided into four sections: "Log In" with a login form, "News & Events" with a date and link, "Profiles" with a list of officials, and "Active Tracker" with a product image.

Center Registration | Online Enquiry | Technical Support  
News & Events | Photo Gallery | Video Gallery

THE PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES

PCPNDT INDORE

**Log In**

Username:  
Password:

Login

☐ Remember me next time  
>> Forgot Password?  
>> Center registration

**News & Events**

16 May 2014  
F-Form Registration

More News >>

**Profiles**

Hon. Chief Minister  
Shri Shivraj Singh Chouhan  
CM's Profile  
CM's Speech

Health Minister  
Shri Dr. Narottam Mishra  
HM Profile

Chief Secretary  
Anthony J.C. Desa  
CS Profile

Collector/DM  
Shri Akash Tripathi  
DM Profile

Active Tracker™

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



The image shows the "PCPNDT / MTP Center Registration" form. It includes a header with the website logo and navigation links. The form has a title "PCPNDT / MTP Center Registration" and a list of radio button options for center types. Below the options is a section for entering a PIN or PNDT registration number, with a "Continue" button. A callout box points to the input field with the text "Enter here pin number". The footer mentions "Powered By: Magnum Opus™".

THE PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES

News & Events | Photo Gallery | Video Gallery

PCPNDT INDORE

**PCPNDT / MTP Center Registration**

☐ New Center with Sonography Facility Only  
☐ New Center with MTP Facility Only  
☐ New Center with Sonography and MTP Facility  
☒ Existing Sonography Center with MTP Facility

☒ Pin Number ☐ PNDT Registration Number

\* Enter Valid PIN / PNDT No to Continue Registration :

Continue

Enter here pin number

Powered By:  Magnum Opus™



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	<input type="text"/>
* Address	<input type="text"/>
Telephone	<input type="text"/> (e.g 0231123456)
Fax	<input type="text"/> (e.g 0231123456)
Mobile	<input type="text"/> (e.g 999999999)
* Email	<input type="text"/> (e.g admin@savethebabygirl.com)

**Centre Information**

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

## Facilities & Equipments Information

Specify Pre-natal diagnostic procedures/tests for which approval is sought:

Leave blank if registration is sought for Genetic Counselling Centre only.

a) Invasive

i) ☐ Amniocentesis ii) ☐ Chromosomal iii) ☐ Chorionic villi aspiration iv) ☐ Biochemical v) ☐ Molecular Studies

b) ☐ Non Invasive Ultrasonography

\* Equipment available with the make and model of each equipment list [Click here to attach](#)

a) Facilities available in the Counseling Centre If available specify here

b) Whether facilities are or would be available in the laboratory /Clinic for following tests? :

i) ☐ Ultrasound ii) ☐ Amniocentesis iii) ☐ Chorionic villi aspiration iv) ☐ Foetoscopy v) ☐ Foetal biopsy

vi) ☐ Cordocentesis

Whether the facilities are available in the Laboratory, clinic for following?

i) ☐ Chromosomal studies ii) ☐ Biochemical Studies iii) ☐ Molecular Studies iv) ☐ Perimplantation genetic diagnosis

\* Name,Qualifications,experience and registration number of employees [Click here to attach](#)

\* State whether the Genetic Counselling Centre/Genetic Laboratory / Genetic Clinic/ Ultrasound Clinic /Imaging centre qualify the requirements laid down in rule 3]

☐ Agree ☒ Not agree

Add equipment  
Detail mention  
below in block 1

Add employee Detail  
mention below in  
block 2

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

**Facilities & Equipments Information**

Specify Pre-natal diagnostic procedures/tests for which approval is sought:

Leave blank if registration is sought for Genetic Counselling Centre only.

a) Invasive

i) ☐ Amniocentesis ii) ☐ Chromosomal iii) ☐ Chorionic villi aspiration iv) ☐ Biochemical v) ☐ Molecular Studies

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\* Equipment available with the make and model of each equipment list [Click here to attach](#)

a) Facilities available in the Counseling Centre If available specify here

b) Whether facilities are or would be available in the laboratory /Clinic for following tests? :

i) ☐ Ultrasound ii) ☐ Amniocentesis iii) ☐ Chorionic villi aspiration iv) ☐ Foetoscopy v) ☐ Foetal biopsy

vi) ☐ Cordocentesis

Whether the facilities are available in the Laboratory, clinic for following?

i) ☐ Chromosomal studies ii) ☐ Biochemical Studies iii) ☐ Molecular Studies iv) ☐ Perimplantation genetic diagnosis

\* Name,Qualifications,experience and registration number of employees [Click here to attach](#)

\* State whether the Genetic Counselling Centre/Genetic Laboratory / Genetic Clinic/ Ultrasound Clinic /Imaging centre qualify the requirements laid down in rule 3]

☐ Agree ☒ Not agree

**Equipments Available**

\* Name of Equipment :

\* Make :

\* Model No. :

\* Manufacturer Name :

Distributor Name :

\* Machine Type : ☐ New ☒ Old

\* Company Purchase Date :  (e.g.15/09/2000)

\* Repurchase Date :  (e.g.15/09/2000)

**Add**

**DECLARATION**

I Shri/Smt./Kum./Dr.  son/daughter/wife of  aged  Years resident of  working as (indicate designation)  in (Indicate name of the organization to be registered)  hereby declare that I have read and understood the Pre-natal (Regulation and Prevention diagnostic techniques of Misuse) Act, 1994 (57 of 1994) and Pre-natal Diagnostic techniques (Regulation and Prevention of Misuse) Rule, 1996.

I undertake to explain the said stated Rules to all employees of the Genetic Counselling Centre / Genetic Clinic/ Ultrasound Clinic/Imaging Centre in respect of

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

### Facilities & Equipments Information

Specify Pre-natal diagnostic procedures/tests for which approval is sought:

Leave blank if registration is sought for Genetic Counselling Centre only.

a) Invasive

i) ☐ Amniocentesis ii) ☐ Chromosomal iii) ☐ Chorionic villi aspiration iv) ☐ Biochemical v) ☐ Molecular Studies

b) ☐ Non Invasive Ultrasonography

\* Equipment available with the make and model of each equipment list [Click here to attach](#)

a) Facility

b) Whether

i) ☐ Ultrasonography

vi) ☐ Cord Blood Sampling

Whether

i) ☐ Chromosomal

\* Name

\* State

required

### Radiologist/Gyn/Others Information

Category :

MMC Registration No :

Name :

Qualification :

Experience (Min. 1 yr Exp.) :  (e.g For 2 years enter 2)

Training (Min 6 Months) :  (e.g For 1 year enter 12)

☐ Agree ☒ Not agree

### DECLARATION

I Shri/Smt/L/Kum./Dr  son/daughter/wife of  aged  Years resident of  working as (Indicate designation)  in (Indicate name of the organization to be registered)  hereby declare that I have read and understood the Pre-natal (Regulation and Prevention diagnostic techniques of Misuse) Act, 1994 (57 of 1994) and Pre-natal Diagnostic techniques (Regulation and Prevention of Misuse) Rule, 1996.

I also undertake to explain the said Act and Rules to all employees of the Genetic Counseling Centre / Genetic Clinic/ Ultrasound Clinic/Imaging Centre in respect of

DECLARATION	
I Shri/Smt./Kum./Dr	son/daughter/wife of
working as (indicate designation)	in (Indicate name of the organization to be registered)
hereby declare that I have read and understood the Pre-natal (Regulation and Prevention diagnostic techniques of Misuse) Act, 1994 (57 of 1994) and Pre-natal Diagnostic techniques (Regulation and Prevention of Misuse) Rule, 1996.	
I also undertake to explain the said Act and Rules to all employees of the Genetic Counseling Centre / Genetic Clinic/ Ultrasound Clinic/Imaging Centre in respect of which registration is sought and to ensure that Act and Rules are fully complied with	
Date	
Place	
Name, designation and signature Of the person authorized to sign on Behalf of the organization to be registered.	
Login Information	
Username	
Password	
Confirm Password	
Email Address	
Security Question	If you forget your password we will ask for the answer to your sec
Security Answer	
Submit	

Avoid to Left space,  
And Type USER ID in Small  
Case to make simple and  
easy to memories. After  
completion of all fields click  
on **SUBMIT BUTTON**

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.



**THE PRE-CONCEPTION &  
PRE-NATAL DIAGNOSTIC  
TECHNIQUES**

[Center Registration](#) | [Online Enquiry](#) | [Technical Support](#)  
[News & Events](#) | [Photo Gallery](#) | [Video Gallery](#)

PCPNDT INDORE

Log in

Username:

Password:

Login

☐ Remember me next time  
[>> Forgot Password?](#)  
[>> Center registration](#)

News & Events

16 May 2014  
F-Form Registration

Active Tracker™

Profiles



Hon. Chief Minister  
Shri Shivraj Singh Chouhan  
CM's Profile  
CM's Speech



Health Minister  
Shri Dr. Narottam Mishra  
HM Profile



Chief Secretary  
Anthony J.C. Desai  
CS Profile



Collector/DM  
Shri Akash Tripathi  
DM Profile

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

Here your center name

DashboardMy ProfileRegistrationTwo Stage F-FormPatientReportsOnline ComplaintNoticeCircular

THE PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES

PCPNDT INDORE

Welcome yashdiniid Logout

PCPNDT Module || MTP Module

Center Dashboard

"THE DASHBOARD FIGURES ARE DISPLAYED FROM 1ST APRIL 2014. TO VIEW THE OLD DATA SELECT THE MONTH"

Dashboard

Select Month & YearDecember2014

Heading	Records till December - 2014	Records on December - 2014
Total number of Registered Patient	148	5
Total number of patient (above age 35)	4	1
Total number of Followup Visit	34	7

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

DashboardMy ProfileRegistration

THE PRE-CONC PRE-NATAL DI/ TECHNIQUES

Edit My Profile

Change Password

Radiologist

Equipment

Center Dashboard

"THE DASHBOARD FIGURES ARE DISPLAYED FROM 1ST APRIL 2014. TO VIEW THE OLD DATA SELECT THE MONTH"

Dashboard

Select Month & YearDecember2014

Heading	Records till December - 2014	Records on December - 2014
Total number of Registered Patient	148	5
Total number of patient (above age 35)	4	1
Total number of Followup Visit	34	7

Edit My Profile-To change the information you have submitted in your form A while registration.

Change Password-To change your old password

Radiologist- To change and Add Radiologist information.

Equipment –To change Equipment information.

## F- Form Registration

[Dashboard](#) [My Profile](#) [Registration](#) [Two Stage F-Form](#) [Patient](#) [Reports](#) [Online Complaint](#) [Notice/Circular](#)

Registration

Welcome yashclinic! [Logout](#)



THE PRE-CONCEPTION &  
PRE-NATAL DIAGNOSTIC  
TECHNIQUES

PCPNDT INDORE

PCPNDT Module || MTP Module

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

Section A:(To be filled in for all Diagnostic Procedures / Tests)

\*Equipment

laesfaf

\*Centre Name

Govt. Hospital

\*Centre Address

Indore

\*Centre Registration No

400

\*Patient Registration Date

16/12/2014

DD/MM/YYYY

Patient Details

Patient Photo

☐ Biometric ☒ Upload

\*Photo Media

Choose file No file chosen

Allowed Image File Extension(jpg,jpeg)

\*First Name

\*Husband/Father Name

\*Last Name

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

Date Of Birth

DD/MM/YYYY

\*Age

\*Number of children

Male

Female

Gender	Age Year	Age Month
Male		

Add

\*Patient Address

\*Area

Urban

\*District

Indore

\*Tahesil

Depalpur

Ward / Village

Other

Enter Village Name

Mobile No

In case if you have more than one machine, select the machine on which the USG is performed.

Capture and upload patient photo.

Add Previous Children information

Email		
Telephone No		
*Referred By	<input checked="" type="radio"/> Doctor <input type="radio"/> Genetic Counselling Centre <input type="radio"/> Self Referral	
*Referred Doctor Name	Other <span style="border: 1px solid black; padding: 2px;">▼</span>	
*Doctor Address		
*Referral Note:		
Last Menstrual Period	<input type="text"/> DD/MM/YYYY	<input type="checkbox"/> Not Known
Weeks of Pregnancy	0 <span style="border: 1px solid black; padding: 2px;">▼</span>	
<b>Section B: To be filled in for performing Non-Invasive diagnostic Procedures/ Tests only</b>		
Procedures carried out by	<input checked="" type="radio"/> Radiologist <input type="radio"/> Gynecologist <input type="radio"/> Directors Of Clinic <input type="radio"/> Registered Medical Practitioner <input type="radio"/> Others	
	Name <span style="border: 1px solid black; padding: 2px;">Select</span> <span style="border: 1px solid black; padding: 2px;">▼</span> Registration No	
Non-Invasive Procedures carried out	<input type="radio"/> (i) Ultrasound <input type="radio"/> (ii) Any Other (specify)	
Representative list of Indications for Ultrasound during Pregnancy		
<input type="checkbox"/> 1. To diagnose intra-uterine and / or ectopic pregnancy and confirm viability. <input type="checkbox"/> 2. Estimation of gestational age(dating). <input type="checkbox"/> 3. Detection of number of fetuses and their chorionicity. <input type="checkbox"/> 4. Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure / MTP failure.		
For Ultrasound please select Indications	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal	
Date on which declaration of pregnant woman/ person was obtained :	<input type="text"/> 16/12/2014 <span style="border: 1px solid black; padding: 2px;">DD/MM/YYYY</span>	
Date(s) on which procedure carried out	<input type="text"/> 16/12/2014 <span style="border: 1px solid black; padding: 2px;">DD/MM/YYYY</span>	
Result of the Non-Invasive Procedure /Test carried out	<input type="text"/> (Give details)	
The result of pre-natal diagnostic procedure were conveyed to	The Patient <span style="border: 1px solid black; padding: 2px;">On</span> <input type="text"/> 16/12/2014 <span style="border: 1px solid black; padding: 2px;">DD/MM/YYYY</span>	
<b>SECTION C: To be filled for performing Invasive Procedures/ Tests only</b>		
Procedures carried out by	<input checked="" type="radio"/> Radiologist <input type="radio"/> Gynecologist <input type="radio"/> Directors Of Clinic <input type="radio"/> Registered Medical Practitioner <input type="radio"/> Others	
	Name <span style="border: 1px solid black; padding: 2px;">Select</span> <span style="border: 1px solid black; padding: 2px;">▼</span> Registration No	
History of genetic/medical disease in the family	No <span style="color: red;">If Yes, then type it in place of No</span>	
Basis of diagnosis	<input type="checkbox"/> (a). Clinical <input type="checkbox"/> (b). Bio-Chemical <input type="checkbox"/> (c). Cytogenetic <input type="checkbox"/> (d). Other	
Indication/s for the diagnosis Procedure		
(A) Previous child/children with	<input type="checkbox"/> (i). Chromosomal disorders <input type="checkbox"/> (ii). Metabolic Disorder <input type="checkbox"/> (iii). Congenital Anomaly <input type="checkbox"/> (iv). Mental Retardation <input type="checkbox"/> (v). Haemoglobinopathy <input type="checkbox"/> (vi). Sex linked Disorders <input type="checkbox"/> (vii). Single gene disorder <input type="checkbox"/> (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	<input type="text"/> DD/MM/YYYY
Invasive procedures carried out ("Tick" on appropriate indication/s)	<input type="checkbox"/> (i). Amniocentesis <input type="checkbox"/> (ii). Chorionic Villi aspiration <input type="checkbox"/> (iii). Foetal Biopsy <input type="checkbox"/> (iv). Cordocentesis <input type="checkbox"/> (v). Other
Any Complication of procedure	Not Applicable
Additional / Laboratory Tests Recommended	<input type="checkbox"/> (i). Chromosomal studies <input type="checkbox"/> (ii). Bio-chemical Studies <input type="checkbox"/> (iii). Molecular Studies <input type="checkbox"/> (iv). Preimplantation genetic diagnosis <input type="checkbox"/> (v). Any Other(Specify)
Invasive procedure / Test carried out Result	(Give details)
Date on which Procedure carried Out	<input type="text"/> DD/MM/YYYY
The result of pre-natal diagnostic procedure were conveyed to	The Patient On <input type="text"/> DD/MM/YYYY
Any indication for MTP as per the abnormality detected in the diagnostic Procedures / Tests	(If give details)
<b>Identity Proof Details</b>	
Id Proof Type	Other
Id Proof Name	
Id Proof No	
Identity Proof Of	<input type="radio"/> Self <input type="radio"/> Husband <input type="radio"/> Father <input type="radio"/> Mother <input checked="" type="radio"/> Other
Identity Proof Of Name	
<b>Identity Proof Details</b>	
Id Proof Type	Other
Id Proof Name	
Id Proof No	
Identity Proof Of	<input type="radio"/> Self <input type="radio"/> Husband <input type="radio"/> Father <input type="radio"/> Mother <input checked="" type="radio"/> Other
Identity Proof Of Name	
<b>Declaration In Case of thumb Impression:</b>	
Name Of the Person Identify by	
Age	
Gender :	Male
Relation if(any)	
Address & Contact No.:	(Give details)
* Date : 16/12/2014	DD/MM/YYYY
* Place : Indore	
<input type="radio"/> Agree <input checked="" type="radio"/> No	
Submit	

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

[Top] 


## Form: Two Stage Registration

Click on Patient Registration

[Dashboard](#) [My Profile](#) [Registration](#) [Two Stage F-Form](#) [Patient](#) [Reports](#) [Online Complaint](#) [Notice/Circular](#)

Patient Registration  
F-Form Registration

Welcome yashclinic! [Logout](#)

 THE PRE-CONCEPTION &  
PRE-NATAL DIAGNOSTIC  
TECHNIQUES

PCPNDT INDORE

PCPNDT Module || MTP Module

Center Dashboard

"THE DASHBOARD FIGURES ARE DISPLAYED FROM 1ST APRIL 2014. TO VIEW THE OLD DATA SELECT THE MONTH"

Dashboard

Select Month & Year December ▼ 2014 ▼

Heading	Records till December - 2014	Records on December - 2014
Total number of Registered Patient	148	5
Total number of patient (above age 35)	4	1
Total number of Followup Visit	34	7

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

**FORM F**  
[See Proviso to Section 4(3), Rule 9(4) and Rule 10(1A)]

Form for maintenance of record in respect of pregnant woman by genetic clinic/ultrasound clinic/imaging centre										
		<a href="#">Back</a> <a href="#">[Bottom]</a>								
Centre Name	Govt. Hospital									
Centre Address	Indore									
Centre Registration No	400									
* Patient Registration Date	<input type="text" value="16/12/2014"/> DD/MM/YYYY									
<b>Patient Name</b>										
Patient Photo	<input type="radio"/> Capture <input checked="" type="radio"/> Upload									
* Photo Media	<input type="button" value="Choose file"/> No file chosen	Allowed Image File Extension (jpg, jpeg, bmp)								
* First Name	<input type="text"/> <input type="text" value="No file chosen"/>									
* Husband/Father Name	<input type="text"/>									
* Last Name	<input type="text"/>									
Note: If you enter Date of Birth then age calculate automatically										
Date Of Birth	<input type="text"/> DD/MM/YYYY									
* Age	<input type="text"/>									
* Age	<input type="text"/>									
* Number of children	<div style="display: flex; justify-content: space-between;"> <span>Male</span> <span>Female</span> </div> <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th style="width: 10%;">Gender</th> <th style="width: 40%;">Age Year</th> <th style="width: 40%;">Age Month</th> <th></th> </tr> </thead> <tbody> <tr> <td>Male</td> <td><input type="text"/></td> <td><input type="text"/></td> <td style="text-align: center;"><b>Add</b></td> </tr> </tbody> </table>		Gender	Age Year	Age Month		Male	<input type="text"/>	<input type="text"/>	<b>Add</b>
Gender	Age Year	Age Month								
Male	<input type="text"/>	<input type="text"/>	<b>Add</b>							
* Patient Address	<input type="text"/>									
* Area	Urban <input type="button" value="v"/>									
* District	Indore <input type="button" value="v"/>									
* Tahasil	Depalpur <input type="button" value="v"/>									
Ward / Village	Other <input type="button" value="v"/> <input type="text"/> Enter Village Name									
Mobile No	<input type="text"/>									
Email	<input type="text"/>									
Telephone No	<input type="text"/>									
* Referred By	<input checked="" type="radio"/> Doctor <input type="radio"/> Genetic Counselling Centre <input type="radio"/> Self Referral									
* Referred Doctor Name	<input type="text"/> <input type="button" value="v"/>									
* Doctor Address	<input type="text"/>									
* Referral Note:	<input type="text"/>									
Last Menstrual Period	<input type="text"/> DD/MM/YYYY	<input type="checkbox"/> Not Known								
Weeks of Pregnancy	0 <input type="button" value="v"/>									
<b>Identity Proof Details</b>										
Id Proof Type	<input type="text" value="Other"/> <input type="button" value="v"/>									
Id Proof Name	<input type="text"/>									
Id Proof No	<input type="text"/>									
Identity Proof Of	<input type="radio"/> Self <input type="radio"/> Husband <input type="radio"/> Father <input type="radio"/> Mother <input checked="" type="radio"/> Other									
Identity Proof Of Name	<input type="text"/>									
<input type="button" value="Submit"/>										
<a href="#">[Top]</a>										

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	<input type="text"/>	Last Name	<input type="text"/>
Husband/Father Name	<input type="text"/>	Age (Or)	<input type="text"/>
From Date	<input type="text"/> MM/dd/yyyy	To Date	<input type="text"/> MM/dd/yyyy

Search
F-Form
New Registration
Print

Select	Sno	First Name ↕	Middle Name ↕	Last Name ↕	Age ↕	Reg. Date ↕
<input type="checkbox"/>	1	Test	Test	Tesgjhq	35	05-12-2014
<input type="checkbox"/>	2	Gsddjgf	Sbdmfv	,nsbmnc	80	05-12-2014
<input type="checkbox"/>	3	Manisha	Pankaj	Khanzode	21	28-11-2014
<input type="checkbox"/>	4	Terst Amin	Sgdj	Dgg	27	14-11-2014
<input type="checkbox"/>	5	Demo	Demo	Demo	25	14-11-2014
<input type="checkbox"/>	6	Demoone	Demo	Demo	25	14-11-2014
<input type="checkbox"/>	7	Online	Test	Today	25	13-11-2014
<input type="checkbox"/>	8	Asdasd	Asdasd	Asdasd	33	13-11-2014
<input type="checkbox"/>	9	Test	Test	Test	25	18-10-2014
<input type="checkbox"/>	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 ↕
<input type="checkbox"/>	1	Test	Test	Tesgjhq	35	05-12-2014
<input type="checkbox"/>	2	Gsddjgf	Sbdmfv	,nsbmnc	80	05-12-2014
<input type="checkbox"/>	3	Manisha	Pankaj	Khanzode	21	28-11-2014
<input type="checkbox"/>	4	Terst Amin	Sgdj	Dgg	27	14-11-2014
<input type="checkbox"/>	5	Demo	Demo	Demo	25	14-11-2014
<input type="checkbox"/>	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
*Tahasil	Indore
Ward / Village	Snehalata Ganj Ward
Mobile No	
Email	
Telephone No	

*Referred By	<input type="radio"/> Doctor <input type="radio"/> Genetic Counselling Centre <input checked="" type="radio"/> Self Referral
*Referral Note:	XZCVXCV

Last Menstrual Period		<input checked="" type="checkbox"/> Not Known
Weeks of Pregnancy	0	

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

Procedures carried out by	<input checked="" type="radio"/> Radiologist <input type="radio"/> Gynecologist <input type="radio"/> Directors Of Clinic <input type="radio"/> Registered Medical Practitioner <input type="radio"/> Others
	Name <input style="width: 150px;" type="text" value="Select"/>
	Registration

		NU	
Non-Invasive Procedures carried out		<input checked="" type="radio"/> (i) Ultrasound <input type="radio"/> (ii) Any Other (specify)	
<div> <input type="checkbox"/> 12. Assessment of liquor amnii.  <input type="checkbox"/> 13. Preterm labour/preterm premature rupture of membranes.  <input type="checkbox"/> 14. Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence etc.).  <input type="checkbox"/> 15. Evaluation of umbilical cord-presentation, insertion, nuchal encirclement, number of vessels and presence of true knot.  <input type="checkbox"/> 16. Evaluation of previous Caesarean Section scars.  <input type="checkbox"/> 17. Evaluation of foetal growth parameters, foetal weight and foetal well being.  <input type="checkbox"/> 18. Colour flow mapping and duplex Doppler studies.  <input type="checkbox"/> 19. Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc and their follow-up.  <input type="checkbox"/> 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.  <input type="checkbox"/> 21. Observation of intra-partum events.  <input type="checkbox"/> 22. Medical/surgical conditions complicating pregnancy.  <input type="checkbox"/> 23. Research/scientific studies in recognised institutions.         </div>			
For Ultrasound please select Indications		<input checked="" type="radio"/> Normal <input type="radio"/> 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		<input checked="" type="radio"/> Radiologist <input type="radio"/> Gynecologist <input type="radio"/> Directors Of Clinic <input type="radio"/> Registered Medical Practitioner <input type="radio"/> Others  Name <input type="text" value="Select"/> Registration No <input type="text"/>	
History of genetic/medical disease in the family		No <span style="color: red;">If Yes, then type it in place of No</span>	
Basis of diagnosis		<input type="checkbox"/> (a). Clinical <input type="checkbox"/> (b). Bio-Chemical <input type="checkbox"/> (c). Cytogenetic <input type="checkbox"/> (d). Other	
Indication/s for the diagnosis Procedure			
(A) Previous child/children with		<input type="checkbox"/> (i). Chromosomal disorders <input type="checkbox"/> (ii). Metabolic Disorder <input type="checkbox"/> (iii). Congenital Anomaly <input type="checkbox"/> (iv). Mental Retardation <input type="checkbox"/> (v). Haemoglobinopathy <input type="checkbox"/> (vi). Sex linked Disorders <input type="checkbox"/> (vii). Single gene disorder <input type="checkbox"/> (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			
Invasive procedures carried out ("Tick" on appropriate indication/s)		<input type="checkbox"/> (i). Amniocentesis <input type="checkbox"/> (ii). Chorionic Villi aspiration <input type="checkbox"/> (iii). Foetal Biopsy <input type="checkbox"/> (iv). Cordocentesis <input type="checkbox"/> (v). Other	
Any Complication of procedure		Not Applicable	
Additional / Laboratory Tests Recommended		<input type="checkbox"/> (i). Chromosomal studies <input type="checkbox"/> (ii). Bio-chemical Studies <input type="checkbox"/> (iii). Molecular Studies <input type="checkbox"/> (iv). Preimplantation genetic diagnosis	

Invasive procedure / Test carried out Result	<input type="text" value="(Give details)"/>	
Date on which Procedure carried Out	<input type="text" value="DD/MM/YYYY"/>	
The result of pre-natal diagnostic procedure were conveyed to	<input type="text" value="The Patient"/>	On <input type="text" value="DD/MM/YYYY"/>
Any indication for MTP as per the abnormality detected in the diagnostic Procedures / Tests	<input type="text" value="(if give details)"/>	
<b>Declaration In Case of thumb Impression:</b>		
Name Of the Person Identify by	<input type="text"/>	
Age	<input type="text"/>	
Gender :	<input type="text" value="Male"/>	
Relation if(any)	<input type="text"/>	
Address & Contact No.:	<input type="text" value="(Give details)"/>	
* Date :	<input type="text" value="16/12/2014"/>	<input type="text" value="DD/MM/YYYY"/>
* Place :	<input type="text" value="Indore"/>	
<input type="radio"/> Agree <input checked="" type="radio"/> Not agree		
<input type="button" value="Submit"/>		
<a href="#">[Top]</a>		

### Indication for pre-natal diagnosis

Previous child/children with	<input type="checkbox"/> (i). Chromosomal disorders <input type="checkbox"/> (ii). Metabolic Disorder <input type="checkbox"/> (iii). Congenital Anomaly <input type="checkbox"/> (iv). Mental Retardation <input type="checkbox"/> (v). Hemoglobinopathy <input type="checkbox"/> (vi). Sex linked Disorders <input type="checkbox"/> (vii). Single gene disorder <input type="checkbox"/> (viii). Other
Advanced maternal age(35)	<input type="text"/>
Mother/Father/Sibling has genetic disease	<input type="text" value="(Specify)"/>
Other	<input type="text" value="(Specify)"/>
*Procedures carried out by	<input checked="" type="radio"/> Radiologist <input type="radio"/> Gynecologist <input type="radio"/> Directors Of Clinic <input type="radio"/> Registered Medical Practitioner <input type="radio"/> Others
	*Name <input type="text" value="Select"/> <input type="button" value="v"/> Registration No <input type="text"/>

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

Non - Invasive	<input type="checkbox"/> (i)Ultrasound (Note :- For Ultrasound please select following indications)
<b>Representative list of Indications for Ultrasound during Pregnancy</b>	
<input type="checkbox"/> To diagnose intra-uterine and / or ectopic pregnancy and confirm viability. <input type="checkbox"/> Estimation of gestational age(dating). <input type="checkbox"/> Detection of number of foetuses and their chorionicity. <input type="checkbox"/> Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure / MTP failure. <input type="checkbox"/> Vaginal bleeding/leaking. <input type="checkbox"/> Follow-up of cases of abortion. <input type="checkbox"/> Assessment of cervical canal and diameter of internal os. <input type="checkbox"/> Discrepancy between uterine size and period of amenorrhea. <input type="checkbox"/> Any suspected adenexal or uterine pathology/abnormality. <input type="checkbox"/> Detection of chromosomal abnormalities, foetal structural defects and other abnormalities and their follow-up. <input type="checkbox"/> To evaluate foetal presentation and position. <input type="checkbox"/> Assessment of liquor amnii. <input type="checkbox"/> Preterm labour/preterm premature rupture of membranes. <input type="checkbox"/> Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence etc )	
Invasive	<input type="checkbox"/> (i). Amniocentesis <input type="checkbox"/> (ii). Chorionic Villi aspiration <input type="checkbox"/> (iii). Foetal Biopsy <input type="checkbox"/> (iv). Cordocentesis <input type="checkbox"/> (v). Other
Any Complication of procedure	<input type="text" value="(Please Specify)"/>
Laboratory Tests Recommended	<input type="checkbox"/> (i). Chromosomal studies <input type="checkbox"/> (ii). Bio-chemical Studies <input type="checkbox"/> (iii). Molecular Studies <input type="checkbox"/> (iv). Preimplantation genetic diagnosis

Result of	
(a).Pre-natal diagnostic procedure	(give details)
(b).Ultrasonography	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal
Date(s) on which procedure carried out	<input type="text" value="22/10/2010"/> e.g. 25/02/1900 (Date/Month/Year)
Date on which constant obtained(In case of invasive)	<input type="text" value="22/10/2010"/> e.g. 25/02/1900 (Date/Month/Year)
The result of pre-natal diagnostic procedure were conveyed to	<input type="text"/> On <input type="text" value="22/10/2010"/> e.g. 25/02/1900 (Date/Month/Year)
Was MTP	<input checked="" type="radio"/> No <input type="radio"/> Advised <input type="radio"/> Conducted Note:- if MTP conducted, please fill MTP form for this patient
* Date : <input type="text" value="22/10/2010"/> e.g. 25/02/1900 (Date/Month/Year) * Place : <input type="text"/>	
<input type="button" value="Submit"/>	

Hear Patient details will Add.

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**Labels with \*marked are compulsory to fill for user**


# Form: Patient

## Follow up visit

Wednesday, 17 Dec, 2014

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 THE PRE-CONCEPTION & PRE-NATAL DIAGNOSTIC TECHNIQUES

PCPNDT INDORE

PCPNDT Module || MTP Module

### Patient Basic Information for FollowUp

**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	<input type="text" value="at"/>	Last Name	<input type="text" value="tes"/>
Husband/Father Name	<input type="text"/>	Age (Or)	<input type="text"/>
From Date	<input type="text" value="MM/dd/yyyy"/>	To Date	<input type="text" value="dd/yyyy"/>

**Search**

1. Search patient and view follow up visit

Select	Sno	WasMTP	First Name	Middle Name	Last Name	Age	Reg. Date
<input checked="" type="checkbox"/>	1		Atest	Ateittt	Test	24	17-11-2014

2. Select patient

**New Registration** **Edit Registration** **Add Visit**


3. click this button to fill visit form

After clicking on Add Visit button following form will open:

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### Patient Visit Information

Back

#### Patient Basic Information

Last Name	lthape	Age (Or)	21
First Name	Ashwini	Birth Date	26-12-1992
Husband/Father Name	Xyz		

Select	Dr. Type	Doctor Name	Registration No	Date of Visit
<input checked="" type="checkbox"/>	Radiologist	Dr.Deepali Gupta	0171102	12-12-2014
<input type="checkbox"/>	Radiologist	Test Radio	420	12-12-2014


Select the tab

New Follow Up Visit Registration View View Follow Up

Click here to add follow up visit form

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

# Form: Delivery



THE PRE-CONCEPTION &  
PRE-NATAL DIAGNOSTIC  
TECHNIQUES

PCPNDT INDORE

PCPNDT Module || MTP Module

### Patient Basic Information for Delivery

#### 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	<input type="text" value="ash"/>	Last Name	<input type="text" value="lith"/>
Husband/Father Name	<input type="text"/>	Age (Or)	<input type="text"/>
From Date	<input type="text" value="MM/dd/yyyy"/>	To Date	<input type="text" value="MM/dd/yyyy"/>

Search

Search the patient details and view delivery report

Select	Sno	WasMTP	First Name	Middle Name	Last Name	Age	Date
<input checked="" type="checkbox"/>	1		Ashwini	Xyz	lithape	21	12-12-2014


Select patient

New Registration

Edit Registration

Add Delivery

Click here to add

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After clicking on Add Delivery button following form will open:

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### Delivery Information

[Back](#)

#### Patient Detail

Last Name	Ithape	Age	21
First Name	Ashwini	Birth Date	26-12-1992
Husband/Father Name	Xyz		

#### Delivery Details

Delivery : Single

Delivery Type	<input checked="" type="radio"/> Normal <input type="radio"/> Caesarean
New Born Baby	<input checked="" type="radio"/> Live <input type="radio"/> IUD (Intra Uterine Death) <input type="text" value="If IUD then specify"/>
Sex	<span>Select</span>
* Delivery Date	<input type="text"/> dd/mm/yyyy
* Delivery Time	<span>Hours</span> <span>Minutes</span> <span>AM</span>

Submit

Add here delivery details and click on submit button

# Reports:

## Monthly Center Report

Wednesday, 17 Dec, 2014

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

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

Note: Add following data to generate Report

Select Month And Year	Jan	2012	
Malformation(specify)			Enter only digits.
Malformation(specify)-Progressive Count			Enter only digits.
Hereditary Hemolytic Anaemia			Enter only digits.
Hereditary Hemolytic Anaemia -Progressive Count			Enter only digits.
Foetoscopy			Enter only digits.
Foetoscopy -Progressive Count			Enter only digits.
MTP Advised Before 12 Weeks			Enter only digits.
MTP Advised After 12 Weeks			Enter only digits.

View Report

Select month and year

Click here to view report

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

Print

PDF

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:

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PCPNDT INDORE

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### Online Complaints

* Complaint Category :	<input type="text" value="select"/>	Select complaint
Mobile	<input type="text" value="658545656"/>	Enter here your contact number and email address
* Email	<input type="text" value="wdwtest@gmail.com"/>	
* Complaint Details	<input type="text"/>	Type your complaint details here
Please enter the code on the right	<input type="text"/>	Type this code in textbox
	<input type="button" value="Submit"/>	Click on submit button to submit complaint





