

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 99999999)
* Email	(e.g admin@savethebabygirl.com)
Centre Information	
*PNDT Centre Registration No	
* Date of Issue	DD/MM/YYY (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 99999999)
* Email	(e.g admin@savethebabygirl.com)
Type of Ownership	OIndividual OPartnership Oco-Operative Ocompany Oother

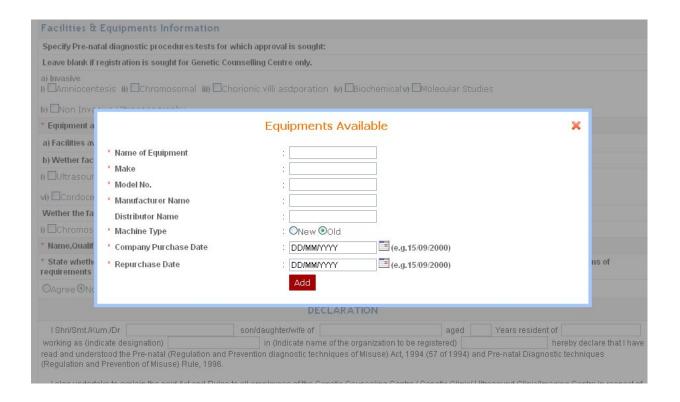
* Type of Institution

select

V

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 asdporation iv) □Biochemicalv) □Molecular Studies		
b) Non Invasive Ultrasonography		
* Equipment available with the made and model of each equipment list Click here to attach	Add equipment	
a) Facilities available in the Counseling Centre If available specify here	Detail mention	
b) Wether facilities are or would be available in the laboratory /Clinic for following tests? :	below in block 1	
i) □Ultrasound ii) □Amniocentesis iii) □Chorionic villi aspiration iv) □Foetoscopy v) □Foetal biopsy		
vi) Cordocentesis		
Wether the facilities are available in the Laboratory, clinic for following?		
i) 🗆 Chromosomal studies ii) 🗀 Biochemincal Studies iii) 🗀 Molecular Studies iv) 🗀 Perimplantation genetic diagn	Add employee Detail mention below in	
* Name,Qualifications,experience and registration number of employees Click here to attach		
 State whether the Genetic Counseling Centre/Genetic Laboratory / Genetic Clinic/Ultrasound Clinic /imaging centre qual requirements laid down in rule 3] 		
O∆gree ONot agree		

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



$[BLOCK\ 2]\ {\it After\ click\ on\ this\ link\ you\ will\ see\ this\ form\ to\ add\ employee\ \ detail}$

Facilities & Equipments Informa	on .	
Specify Pre-natal diagnostic procedures &	s for which approval is sought:	
Leave blank if registration is sought for Ge	tic Counselling Centre only.	
a) Invasive i) □Amniocentesis ii) □Chromosomal b) □Non Invasive Ultrasonography	□Chorionic villi asdporation M □Biochemical V □Molecular Studies	
* Equipment available with the made and n a) Facili b) Weth i) Outr ' Category ' MMC Registration No ' Name Wether ' Qualification i) Ohr ' Experience(Min. 1 yr Exp.) ' Training(Min 6 Months) * State requirer	Radiologist/Gyn/Others Information Select (e.g For 2 years enter 2) (e.g For 1 year enter 12)	
OAgree Not agree		
	DECLARATION	
I Shri/Smt./Kum./Dr	son/daughter/wife of aged Years resident of	
(Regulation and Prevention of Misuse) Rule,	in (Indicate name of the organization to be registered) hereby declare and Prevention diagnostic techniques of Misuse) Act, 1994 (57 of 1994) and Pre-natal Diagnostic techniques 196. Rules to all employees of the Genetic Counseling Centre / Genetic Clinic/Ultrasound Clinic/Imaging Centre in	

	DECLARATION	
(Regulation and Prevention of Misuse)	son/daughter/wife of in (Indicate name of the organization to be egulation and Prevention diagnostic techniques of Misuse) Act, 19 Rule, 1996. Act and Rules to all employees of the Genetic Counseling Centre sure that Act and Rules are fully complied with	994 (57 of 1994) and Pre-natal Diagnostic techniques
Date 30/10/2010 Place		Name, designation and signature Of the person authorized to sign on Behalf of the organization to be registered.
Login Information		Avoid to Left space,
Username Password	minimum minimum	And Type USER ID in Small
Confirm Password		Case to make simple and
Email Address	(e.g admin@savethebabygir	easy to memories. After
Security Question	If you forget your password we will ask for the answer to you	a manufation of all fields aliely
Security Answer	Submit	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.



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



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



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.

"THE DASHBOARD FIGURES ARE DISPLAYED FROM

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

F- Form Registration



Email			
Telephone No			
*Referred By	■Doctor □Genetic Counselling Centre □Self Refe	erral	
Referred Doctor Name	Other ▼		
*Doctor Address	A		
*Referal Note:	4		
Last Menstrual Period	DD/MM/YYYY		Not Known
Weeks of Pregnancy	0 •		
Section B: To be filled in for perforn	ning Non-Invasive diagnostic Procedures/I	octe only	
Procedures carried out by	Radiologist Ogynecologist Directors Of Clinic Registered Medical Practi Others Name Select Registration No	Select Doo	ctor Name
Non-invansive Procedures carried out	(i)Ultrasound (ii)Any Other (specify)		
	0.00 124 124 124 124 124 124 124 124 124 124	11077103	
\square_1 , To diagnose intra-uterine and / or ectopi	prentative list of Indications for Ultrasound during Pregna ic pregnancy and confirm viability.	ancy	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure	3.00	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD insitu	ic pregnancy and confirm viability.	3.00	
 1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure	3.00	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ For Ultrasound please select Indications Date on which declaration of pregnant woman/	eir chorionicity. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal	3.00	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD institutions For Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained:	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MM/YYYY	3.00	
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1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ For Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-Invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performi Procedures carried out by	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MM/YYYY (Give details) re conveyed to The Patient On 16/12/20 Radiologist Gynecologist Directors Of Clinic Registered Medical Practitions Others Name Select Registration No	e / MTP failure.	/MM/YYYY
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ For Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-Invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performi Procedures carried out by	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MM/YYYY (Give details) re conveyed to The Patient On 16/12/20 Radiologist Gynecologist Directors Of Clinic Registered Medical Practitions Others Name Select Registration No	D14 DD or	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ 4. Suspected pregnancy with IUCD in-situ 5. To Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-Invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performing the procedure of the contraction of the c	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MM/YYYY 16/12/2014 DD/MM/YYYY (Give details) re conveyed to The Patient On 16/12/20 ing Invasive Procedures/ Tests only Radiologist Gynecologist Others Name Select Registration No	D14 DD or	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ 5. For Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-Invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performi Procedures carried out by History of genetic/medical disease in the family Basis of diagnosis	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MM/YYYY 16/12/2014 DD/MM/YYYY (Give details) re conveyed to The Patient On 16/12/20 ing Invasive Procedures/ Tests only Radiologist Gynecologist Others Name Select Registration No	on the property of the propert	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ 5. For Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performi Procedures carried out by History of genetic/medical disease in the family Basis of diagnosis Indication/s for the diagnosis Procedure	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014 DD/MMYYYYY 16/12/2014 DD/MMYYYYY (Give details) re conveyed to The Patient On 16/12/20 ing Invasive Procedures/ Tests only Radiologist Gynecologist Others Name Select Registration No No (a). Clinical (b). Bio-Chemical (c). Cytogenetic (ii). Chromosomal disorders (ii). Metabolic Disord (iii). Cogenital Anomaly (iv). Mental Retarda (v). Haemoglobinopathy (vi). Sex linked Disorders (vi).	on the property of the propert	
1. To diagnose intra-uterine and / or ectopi 2. Estimation of gestational age(dating). 3. Detection of number of foetuses and the 4. Suspected pregnancy with IUCD in-situ 4. Suspected pregnancy with IUCD in-situ 5. To Ultrasound please select Indications Date on which declaration of pregnant woman/ person was obtained: Date(s) on which procedure carried out Result of the Non-Invasive Procedure /Test carried out The result of pre-natal diagnostic procedure were SECTION C: To be filled for performi Procedures carried out by History of genetic/medical disease in the family Basis of diagnosis Indication/s for the diagnosis Procedure (A) Previous child/children with	ic pregnancy and confirm viability. eir chorionicity. or suspected pregnancy following contraceptive failure Normal Abnormal 16/12/2014	on the property of the propert	

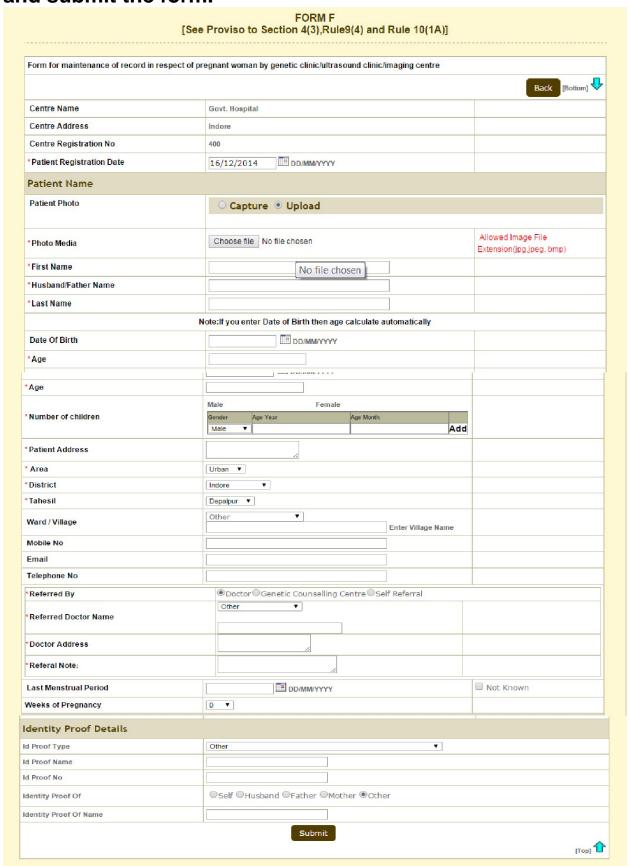
Date on which consent of pregnant woman / person was obtained in Form F prescribed in PC/PNDT Act, 1994	DD/MM/YYYY		
Invasive procedures carried out ("Tick" on appropriate indication/s)	☐(i). Amniocentesis ☐(ii). Chorionic Villi aspiration ☐(iii). Foetal Biopsy ☐(iv). Cordocentesis ☐(v). Other		
Any 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 we	re conveyed to The Patient On DD/MM/YYYY		
Any indication for MTP as per the abnormality d diagnostic Procedures / Tests	etected in the (If give details)		
Identity Proof Details			
d Proof Type	Other ▼		
d Proof Name			
d 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 OHusband OFather OMother Other		
Identity Proof Of Name			
Declaration In Case of thumb Impre	ssion:		
Name Of the Person Indentify by			
Age			
Gender:	Fill all compulsory Filled then Click Agree		
Gender: Relation if (any) Fill all compulsory Filled then Click Agree			
Address & Contact No.: * Date : 16/12/2014	button and submit Form.		
* Place : Indore	○Agree ® No		
	- Agree - III		
	Submit		

Click on Patient Registration

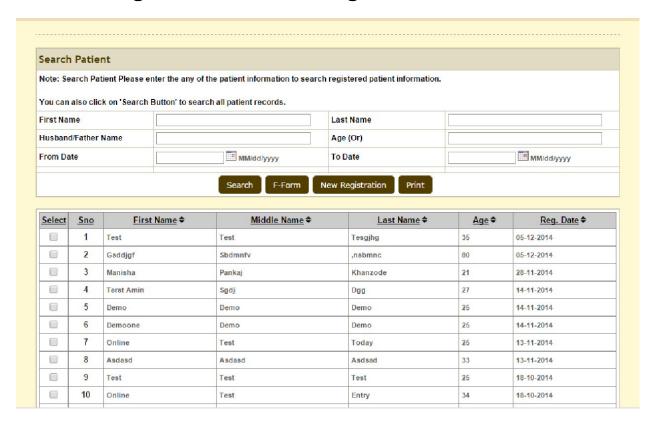
Form: Two Stage Registration



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



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



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.



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 p	or egilant woman	by genetic chinera	in a sound clim	annuguig centre		
					В	ack [Bottom]
Equipment		aesfaf		▼		
Centre Name		Govt. Hospital				
Centre Address		Indore			文章 第	
Centre Registration No		400			大学教 及	NA.
Patient Registration Date		05/12/2014	DD/MM/YYYY			
atient 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 liv	ring Daughters	with age of each li	ving daughter (in years o	or months):
Patient Address		SVCXV	h			
Area		Urban				
District		Indore				
Tahesil		Indore				
Ward / Village		Snehalata Gan	j Ward			
Mobile No						
Email						
Telephone No						
Referred By	Opertor	Genetic Counse	lling Centre ®	Solf Referral		
Referal Note:	xzcvxcv	Contracto Courto	ming control	DOI TOTOTO		
Referat Note:			10			
Last Menstrual Period					Not Known	
Veeks of Pregnancy		0				
ection B: To be filled in for perfor	ming Non-In	vasive diagno	stic Proced	ures/ Tests on	У	
Procedures carried out by		Radiologist	OGynec			
		Name	Select		▼	
		Registration	SCICUL			

	NU
Non-Invansive Procedures carried out	○(i)Ultrasound ○(ii)Any Other (specify)
atc.). 15. Evaluation of umbilical cord-presentation, insertion 16. Evaluation of previous Caesarean Section scars. 17. Evaluation of foetal growth parameters, foetal weig 18. Colour flow mapping and duplex Doppler studies. 19. Ultrasound guided procedures such as medical term 20. Adjunct to diagnostic and therapeutic invasive intermatering, foetal skin biopsy, amnioinfusion, intrauterine is 21. Observation of intra-partum events. 22. Medical/surgical conditions complicating pregnancy. 23. Research/scientific studies in recognised institution	and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence , nuchal encirclement. number of vessels and presence of true knot. pht and foetal well being. nination of pregnancy, external cephalic version etc and their follow-up. rventions such as chorionic villus sampling(CVS), amniocenteses, foetal blood infusion, placement of shunts etc.
4	F
For Ultrasound please select Indications	Normal OAbnormal
Date on which declaration of pregnant woman/person was obtained:	16/12/2014 ED/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 Invasiv	e Procedures/ Tests only
	Objrectors Of Clinic Registered Medical Practitioner Oothers Name Select Registration No
istory of genetic/medical disease in the family	No If Yes, then type it in place of No
asis of diagnosis	(a), Clinical (b), Bio-Chemical (c), Cytogenetic (d), Other
dication/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
ate on which consent of pregnant woman / person was btained in Form F prescribed in PC/PNDT Act, 1994	□ DD/MM/YYYY
vasive procedures carried out ("Tick" on appropriate dication/s)	(i). Amniocentesis (ii). Chorionic Villi aspiration (iii). Foetal Biopsy (iv). Cordocentesis (v). Other
ny Complication of procedure	Not Applicable
additional / Laboratory Tests Recommended	□(i). Chromosomal studies □(ii). Bio-chemical Studies

Invasive procedure / Test carried out Result	(Give details)
Date on which Procedure carried Out	DD/MM/YYY
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	
	○ Agree ● Not agree
	Submit

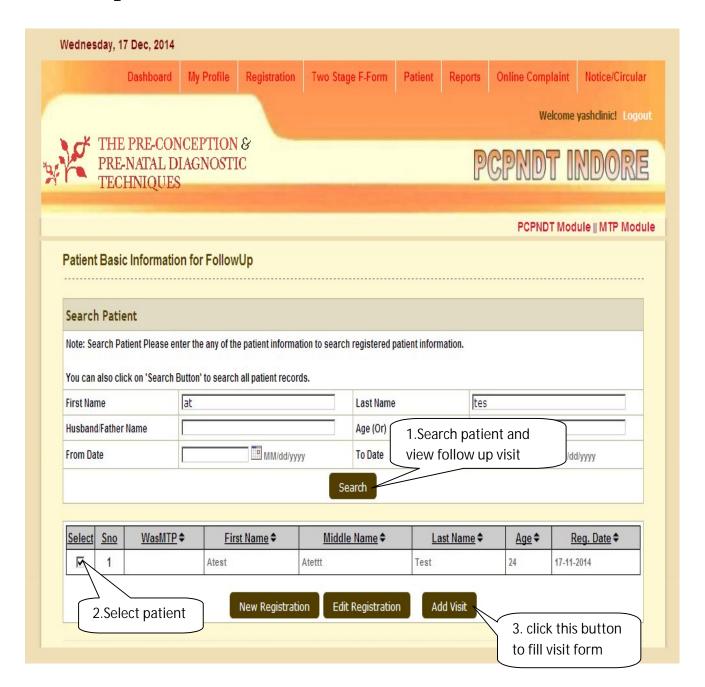
Indication for any matel diseases	
Indication for pre-natal diagnosis Previous child/children with	□(i). Chromosomal disorders □(ii). Metabolic Disorder □(iii). Cogenital Anomaly □(iv). Mental Retardation □(v). Hemoglobinopathy □(vi). Sex linked Disorders □(vii). Single gene disorder □(viii). Other
Advanced maternal age(35)	
Mother/Father/Sibling has genetic disease	(Specify)
Other	(Specify)
*Procedures carried out by	●Radiologist
(Note :- Please Select either Invasive or	Non-Invasive)
Non - Invasive	☐(i)Ultrasound (Note:- For Ultrasound please select following indications)
□Vaginal bleeding/leaking. □Follow-up of cases of abortion. □Assessment of cervical canal and diameter of □Discrepancy between uterine size and period □Any suspected adenexal or uterine patholog: □Detection of chromosomal abnormalities, foel □To evaluate foetal presentation and position □Assessment of liquor amnii. □Preterm labour/preterm premature rupture o	orionicity. Is pected pregnancy following contraceptive failure / MTP failure. If internal os. If of amenorrhea. If of amenorrhea. If internal ity. Ital structural defects and other abnormalities and their follow-up. Ital structural defects and other abnormalities and their follow-up.
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

Result of	
a).Pre-natal diagnostic procedure (give details)	
(b).Ultrasonography	
Date(s) on which procedure carried out	22/10/2010 e.g. 25/02/1900 (Date/Month Year)
Date on which constent obtained(In case of invasive)	22/10/2010 e.g. 25/02/1900 (Date/Month Year)
The result of pre-natal diagnostic procedure were conveyed to	On 22/10/2010 e.g. 25/02/1900 (Date/Month/Year)
Was MTP	OAdvised Oconducted Note:- if MTP conducted, please fill MTP form for this patient
* Date : 22/10/2010	Year)
	Hear Patient details will Add. ormation Schemes Online Complaint News & Events © savethebabyoirl.com 2010. All rights Reserved.

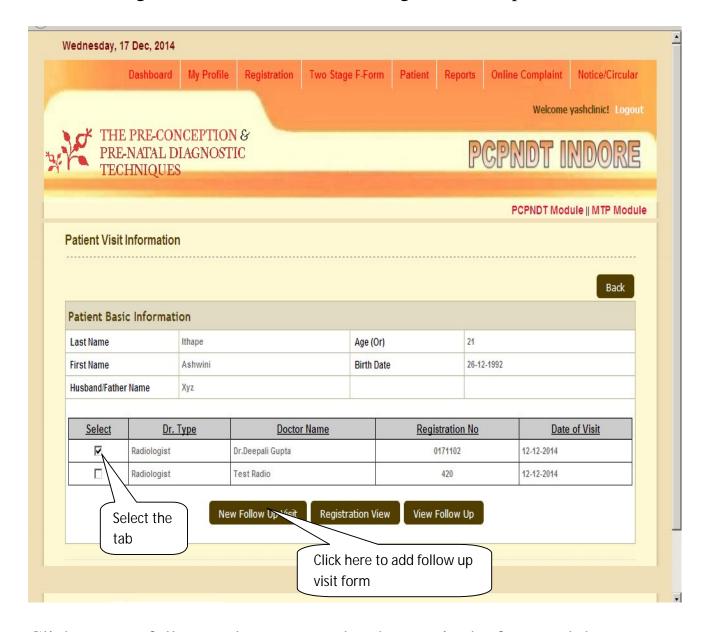
Labels with *marked are compulsory to fill for user

Form: Patient

Follow up visit



After clicking on Add Visit button following form will open:

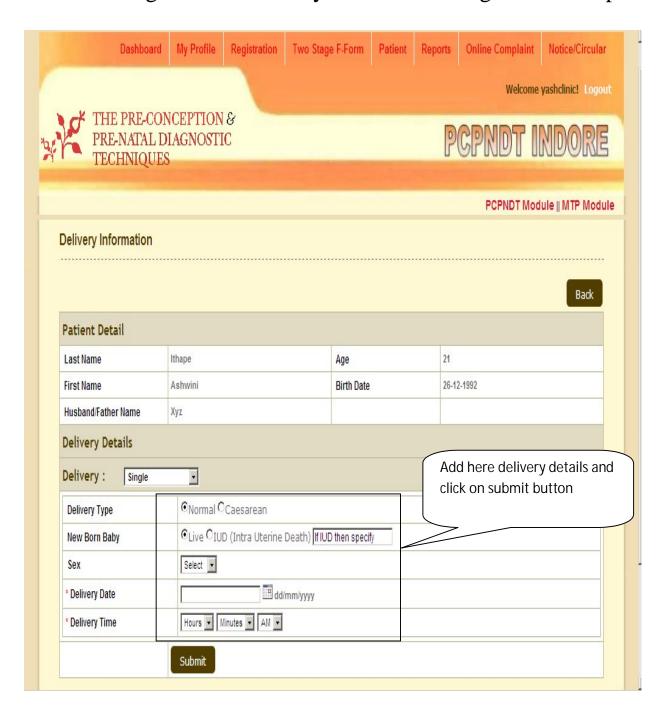


Click on new follow up button to make changes in the form and then submit the form.

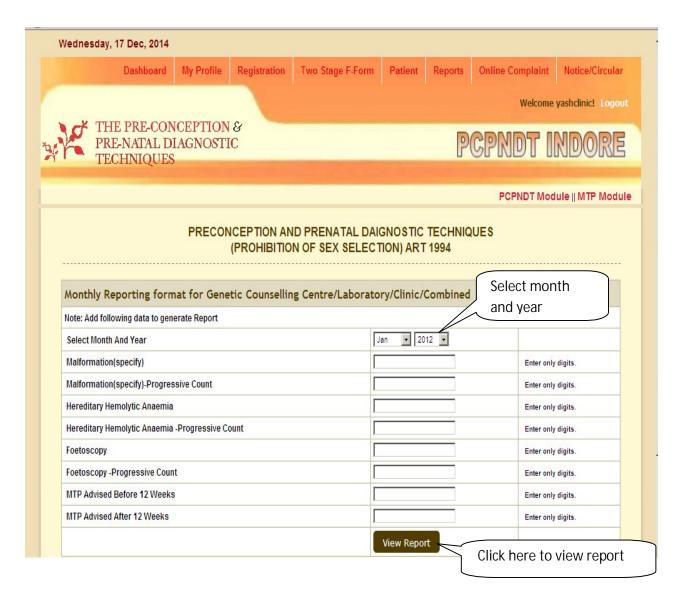
Form: Delivery



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:

