

MINISTRY OF HEALTH AND FAMILY WELFARE

NOTIFICATION

New Delhi, the 31st January, 2014

G.S.R. 77 (E).—In exercise of the powers conferred by Section 32 of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (57 of 1994), the Central Government hereby makes the following rules further to amend the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996, namely :—

1. (1) These rules may be called the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Amendment Rules, 2014.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. In the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996, for Form F, the following Form shall be substituted:

[See Proviso to Section 4(3), rule 9(4) and rule 10(1A)]

**FORM FOR MAINTENANCE OF RECORD IN CASE OF PRENATAL DIAGNOSTIC TEST /PROCEDURE
BY GENETIC CLINIC/ULTRASOUND CLINIC/IMAGING CENTRE**

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

1. Name and complete address of Genetic Clinic/Ultrasound Clinic/Imaging centre: _____

2. Registration No. (Under PC& PNDT Act, 1994) _____

3. Patient's name _____ Age _____

4. Total Number of living children : _____

(a) Number of living Sons with age of each living son (in years or months): _____

(b) Number of living Daughters with age of each living daughter (in years or months) : _____

5. Husband's /Wife's/ Father's / Mother's Name : _____

6. Full postal address of the patient with Contact Number, if any _____

7. (a) Referred by (Full name and address of Doctor(s)/ Genetic Counseling Centre): _____

(Referral slips to be preserved carefully with Form F)

(b) **Self-Referral** by Gynaecologist/Radiologist/Registered Medical Practitioner conducting the diagnostic procedures: _____

(Referral note with indications and case papers of the patient to be preserved with Form F)

(Self-referral does not mean a client coming to a clinic and requesting for the test or the relative/s requesting for the test of a pregnant woman)

8. Last menstrual period or weeks of pregnancy : _____

Section B: To be filled in for performing non-invasive diagnostic Procedures/ Tests only

9. Name of the doctor performing the procedure/s : _____

469 40714-3

10. Indication/s for diagnosis procedure _____ (specify with reference to the request made in the referral slip or in a self-referral note)

(Ultrasonography prenatal diagnosis during pregnancy should only be performed when indicated. The following is the representative list of indications for ultrasound during pregnancy. (Put a "Tick" against the appropriate indication/s for ultrasound)

- i. To diagnose intra-uterine and/or ectopic pregnancy and confirm viability.
- ii. Estimation of gestational age (dating).
- iii. Detection of number of fetuses and their chorionicity.
- iv. Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure/MTP failure.
- v. Vaginal bleeding/leaking.
- vi. Follow-up of cases of abortion.
- vii. Assessment of cervical canal and diameter of internal os.
- viii. Discrepancy between uterine size and period of amenorrhea.
- ix. Any suspected adenexal or uterine pathology/abnormality.
- x. Detection of chromosomal abnormalities, fetal structural defects and other abnormalities and their follow-up.
- xi. To evaluate fetal presentation and position.
- xii. Assessment of liquor amnii.
- xiii. Preterm labor / preterm premature rupture of membranes.
- xiv. Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retro placental hemorrhage, abnormal adherence etc.).
- xv. Evaluation of umbilical cord – presentation, insertion, nuchal encirclement, number of vessels and presence of true knot.
- xvi. Evaluation of previous Caesarean Section scars.
- xvii. Evaluation of fetal growth parameters, fetal weight and fetal well being.
- xviii. Color flow mapping and duplex Doppler studies.
- xix. Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc. and their follow-up.
- xx. Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVS), amniocenteses, fetal blood sampling, fetal skin biopsy, amnio-infusion, intrauterine infusion, placement of shunts etc.
- xxi. Observation of intra-partum events.
- xxii. Medical/surgical conditions complicating pregnancy.
- xxiii. Research/scientific studies in recognized institutions.

11. Procedures carried out (Non-Invasive) (Put a "Tick" on the appropriate procedure)

i. Ultrasound

(Important Note: Ultrasound is not indicated/advised/performed to determine the sex of fetus except for diagnosis of sex-linked diseases such as Duchene Muscular Dystrophy, Hemophilia A & B etc.)

ii. Any other (specify) _____

12. Date on which declaration of pregnant woman/ person was obtained : _____

13. Date on which procedures carried out: _____
14. Result of the non-invasive procedure carried out (*report in brief of the test including ultrasound carried out*)

15. The result of pre-natal diagnostic procedures was conveyed to _____ on _____
16. Any indication for MTP as per the abnormality detected in the diagnostic procedures/ tests _____

Date:

Name, Signature and Registration Number with Seal of the
Gynaecologist/Radiologist/Registered Medical Practitioner
performing Diagnostic Procedure/s

Place:

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

17. Name of the doctor/s performing the procedure/s: _____
18. History of genetic/medical disease in the family (specify): _____ Basis of diagnosis ("Tick" on appropriate basis of diagnosis):
(a) Clinical (b) Bio-chemical
(c) Cytogenetic (d) other (e.g. radiological, ultrasonography etc.-specify)
19. Indication/s for the diagnosis procedure ("Tick" on appropriate indication/s):
A. Previous child/children with:
(i) Chromosomal disorders (ii) Metabolic disorders
(iii) Congenital anomaly (iv) Mental Disability
(v) Haemoglobinopathy (vi) Sex linked disorders
(vii) Single gene disorder (viii) Any other (specify)
B. Advanced maternal age (35 years)
C. Mother/father/sibling has genetic disease (specify)
D. Other (specify) _____
20. Date on which consent of pregnant woman / person was obtained in Form G prescribed in PC&PNDT Act, 1994 : _____
21. Invasive procedures carried out ("Tick" on appropriate indication/s)
i. Amniocentesis ii. Chorionic Villi aspiration
iii. Fetal biopsy iv. Cordocentesis
v. Any other (specify)
22. Any complication/s of invasive procedure (specify) _____

23. Additional tests recommended (Please mention if applicable)
(i) Chromosomal studies (ii) Biochemical studies
(iii) Molecular studies (iv) Pre-implantation gender diagnosis
(v) Any other (specify)
24. Result of the Procedures/ Tests carried out (*report in brief of the invasive tests/ procedures carried out*) _____

25. Date on which procedures carried out: _____
26. The result of pre-natal diagnostic procedures was conveyed to _____ on _____

27. Any indication for MTP as per the abnormality detected in the diagnostic procedures/ tests _____

Date :
Place

Name, Signature and Registration Number with Seal of the
Gynaecologist/Radiologist/Registered Medical Practitioner
performing Diagnostic Procedure/s

SECTION D: Declaration

**DECLARATION OF THE PERSON UNDERGOING
PRENATAL DIAGNOSTIC TEST/ PROCEDURE**

I, Mrs./Mr. _____ declare that by undergoing
_____ Prenatal Diagnostic Test/ Procedure. I do not want to know the sex of my foetus.

Date:

Signature/Thumb impression of the person undergoing
the Prenatal Diagnostic Test/ Procedure

In Case of thumb Impression:

Identified by (Name) _____ Age: _____ Sex: _____
Relation (if any): _____ Address & Contact No.. _____

Signature of a person attesting thumb impression: _____ Date: _____

**DECLARATION OF DOCTOR/PERSON CONDUCTING
PRE NATAL DIAGNOSTIC PROCEDURE/TEST**

I, _____ (name of the person conducting ultrasonography/image scanning) declare
that while conducting ultrasonography/image scanning on Ms./ Mr. _____ (name of the pregnant
woman or the person undergoing pre natal diagnostic procedure/ test), I have neither detected nor disclosed the sex of
her fetus to anybody in any manner.

Signature: _____

Date:

Name in Capitals, Registration Number with Seal of the
Gynaecologist /Radiologist/Registered Medical Practitioner
Conducting Diagnostic procedure

[F No. V.11011/6/2013-PNDT]

Dr RAKESH KUMAR, Jt. Secy.

Note : The principal notification was published in the Gazette of India, *vide* G.S.R 1 (E), dated the 1st January, 1996 and amended *vide* notification numbers G.S.R 109 (E), dated the 14th February, 2003; G.S.R 426 (E), dated the 31st May, 2011; G.S.R 80 (E), dated the 7th February, 2012; G.S.R 418 (E), dated the 4th June, 2012 and G.S.R 13(E), dated the 9th January, 2014.