GeNeCaRe
Diagnostics & Research Centre
WE CARE FOR YOUR GENES

FORM G
[See rule 10]
FORM OF CONSENT
(for invasive techniques)

I, _____ wife / daughter of _____ age ___ years, residing at _____ hereby state that I have been explained fully the probable side Effects and after effects of the pre-natal diagnostic procedures.

I wish to undergo the preimplantation / pre-natal diagnostic technique / test / procedures in my own interest to find out the possibility of any abnormality (i.e. disease / deformity / disorder) in the child I am carrying.

I undertake not to terminate the pregnancy if the pre-natal procedure / technique / test conducted show the absence of disease / deformity / disorder.

I understand that the sex of the foetus will not be disclosed to me.

I understand the breach of this understanding will make me liable to penalty as prescribed in the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (57 of 1994) and rules framed thereunder.

Date:
Place: SURAT

Signature of the pregnant woman.

X

I have explained the contents of the above to the patient and her companion (Name _____ _____Address_____ Relationship _____ ) in a language she / they understand.

Name, signature and registration number of Gynecologist / Medical Geneticist / Radiologist / Pediatrician / Director of the clinic / Centre / Laboratory

Date:

Name, address and registration number of Genetic Clinic / Institute.
**GENECARE DIAGNOSTICS & RESEARCH CENTER**
D-202/203,2ND Floor, Shreepad World, Beside Nayara Petrol Pump, Pal, Adajan, Surat-395009
**Registration No.: GJ-05/SUR/PCPNDT/1476/2025**

SEAL

GeNeCaRe
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FORM E
[See Rule 9(3)]
FORM FOR MAINTENANCE OF RECORDS BY GENETIC LABORATORY

1. Name and address of Genetic Laboratory: **GENECARE DIAGNOSTICS & RESEARCH CENTER**
**D-202/203,2ND Floor, Shreepad World, Beside Nayara Petrol Pump, Pal, Adajan, Surat-395009**
2. Registration No.: **GJ-05/SUR/PCPNDT/1476/2025**
3. Patient's name:
4. Age: years
5. Husband's / Father's name:
6. Full address with Tel. No., if any:
7. Referred by / sample sent by:
(full name and address of Clinic)
(referral note to be preserved
carefully with case papers)
8. Type of sample:
(Maternal blood / Chorionic Villi
Sample / Amniotic fluid / Foetal
Blood or other foetal tissue (specify)

9. Specify indication for pre-natal diagnosis:
    a. Previous child / children with
    i. Chromosomal disorders
    ii. Metabolic Disorders
    iii. Malformations
    iv. Mental Retardation
    v. Hereditary hemolytic anemia
    vi. Sex-linked disorders
    vii. Single gene disorder
    viii. Any other (specify)

b. Advanced maternal age (35 years or above)
c. Mother / Father / Sibling having genetic disease (specify)
d. Other (specify)
10. Laboratory tests carried out (give details):
    i. Chromosomal studies
    ii. Biochemical studies
    iii. Molecular studies
    iv. Preimplantation genetic diagnosis
11. Result of diagnosis (if abnormal, give details): Normal / Abnormal
12. Date(s) on which tests carried out:
The results of the pre-natal diagnostic tests were conveyed to _____on _____

Place: SURAT
Date:

Name, signature and Registration No. of the
Medical Geneticist / Director of the Institute.