

FORM- G

[Refer rule 10]

FORM OF CONSENT

(For invasive techniques)

I, _____ wife/daughter of
_____, age __ years residing at

(full address) 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 fetus will not be disclosed to me.

I understand that breach of this undertaking 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:

Signature of the patient

I have explained the contents of the above to the patient and her companion

(Name _____ Address _____
_____) Relationship _____) In a language she/they understand.

Date:

Place:

Signature of the patient

Name, signature and registration Number of
Gynaecologist/Medical Genetiscist/Radiologist/
Paediatrician/Director of the Clinic/Centre/Laboratory

Name, address and registration number of Genetic
Clinic/Institute [SEAL]