Birth defects notification form

Genetics reference number ………………    Code ……………………………………………

1. GENERAL INFORMATION:-
a. Province …………………………………………      b. District ……………………………….….
c. Name of Hospital/Facility……………………………………………………………………………….
d. Facility/Ward telephone number ………………………   f. Date ………/…………/….…….
   day             month                      year
e. Name of person notifying ………………………………………

2. PARTICULARS OF MOTHER:-
a. Name ……………………………………... b. Date of birth/Age ………/………/………….
   first                    surname  day           month                      year
d. Gender Male Female Ambiguous       e. Population group African White  Coloured Asiatic Other  Specify  …………………………………
f. Birth status Live Birth                     Still Birth                   Therapeutic Abortion                Miscarriage
g. Birth weight <2500g   ≥ 2500g
h. Gestational age <37 weeks  ≥ 37 weeks

4. PLACE OF BIRTH (Please tick the appropriate block)
a. Urban Hospital b. Rural Hospital             c. Clinic               d. Home        e. Born before arrival f. Referred
   to another Hospital? Yes  No        g. Referred from another Hospital? Yes  No
h. If yes, name of that Hospital …………………………………………………………………

5. DIAGNOSIS:-
5.1 PRIORITY BIRTH DEFECTS (Please tick the appropriate block)
a. Neural Tube Defects Anencephaly Encephalocele Spina Bifida
b. Albinism c. Down Syndrome d. Tallipes equinovarus/club feet e. Fetal Alcohol Syndrome
f. Clefts Cleft lip & palate Cleft lip only Cleft palate only
Comments: ……………………………………………………………………………………………

5.2 OTHER BIRTH DEFECTS (Other birth defects that have not been included in item 5.1)
g. Genitals h. Urinary System i. Arms j. Legs k. Hands l. Feet
Description ……………………………………………………………………………………………

Section 5 completed by Doctor Registered Nurse Additional Genetic Training    Yes   No

6. INVESTIGATIONS REQUESTED (Please tick the appropriate block)
a. Chromosomal/cytogenetic b. Biochemical/metabolic
c. DNA/molecular d. No investigation necessary
e. Other diagnostic or screening procedure Specify ……………………………………………

7. COUNSELING GIVEN (BY):- Please tick the appropriate block
Clinical geneticist    Medical doctor    Registered Nurse Additional Genetic Training    Yes   No
Geneic counselor     No counseling given