

**Department of Laboratory Medicine,
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INFORMED CONSENT FOR GENETIC TESTING

Patient Name _____ **Date of Birth** _____

Genetic test to be performed _____

Purpose of Testing

I understand that blood samples are being drawn on me/my minor child to determine if I/my child has the above listed genetic disorder or am a carrier of a disease gene responsible for the disorder. It is the responsibility of the referring physician to ensure that I understand the implications of this testing. I understand that participation in this testing is voluntary.

Accuracy of Testing

I understand that the accuracy of the testing is limited to the techniques used and the information that I provide regarding myself (my child), the medical history of family members, and biological relationships in my family. It is the responsibility of the referring physician to explain the limitations of the testing. In addition, nonpaternity may be detected in some family-based studies, and this result may be reported to the referring physician. I understand that, as will all complex testing, there is always a chance of error or sample failure.

Reporting of results

I understand that the results of this testing will be reported only through the referring physician, or through a professional designated by the referring physician, such as a genetic counselor. All results are confidential and will be reported to other individuals only with my written consent, unless otherwise required by law.

Disposition of Samples

I understand that an aliquot of my sample will be kept with identifiers intact, and may be available for additional testing as ordered by my physician. I will not consider this as a banking procedure, and the laboratory will not be responsible for ensuring that the sample is available in the future. The remainder of my DNA can be used for research-based testing with the option that I have checked below.

I give the following permission regarding research use of the unused portion of my sample (please choose ONE):

[Please note: if neither option is marked, the first option will apply.]

_____ Can be used for research purposes including studies designed to investigate the cause of my (child's) condition without identifying information removed. Results may be communicated through the referring physician.

_____ Can be used for research purposes only after identifiers are removed from the sample. I understand that I will not be given any results from the testing, because the sample will be anonymous.

Signature of Patient/Parent: I consent to participate (or have my child participate) in genetic testing for the above mentioned condition. The testing has been explained to me, including its limitations and implications, and I have been given the opportunity to ask questions which have been answered in a satisfactory manner.

_____ Date _____

Signature of Ordering Clinician: I have explained the testing, limitations, consent, and implications to the patient/parent and accept responsibility for ensuring genetic counseling is provided.

_____ Date _____

It is recommended that a copy of the signed consent be provided to the patient/parent.