

DNA ANALYSIS PATIENT INFORMATION AND CONSENT

LAST NAME:		FIRST NAME:		MI:
Date of Birth / /	Sex	M	F	Hospital/ID Number
<u>PATIENT ADDRESS</u> _____ _____ _____ _____				I REQUEST DNA ANALYSIS FOR: _____(genetic condition) The intended purpose is: <input type="checkbox"/> Prenatal <input type="checkbox"/> Screening <input type="checkbox"/> Diagnosis <input type="checkbox"/> Carrier status <input type="checkbox"/> Presymptomatic <input type="checkbox"/> Predictive <input type="checkbox"/> Other _____

I give my consent to have my sample sent to _____ for DNA testing for the above-designated genetic condition.

I have discussed the principles, the benefits and the risks of this testing with a physician/genetic counselor, and I have had my questions answered. I understand the following benefits, risks and limitations:

1. While DNA testing is a valuable diagnostic tool, it may not always give a definite answer about the genetic status of an individual. More specific information will be reported to me with the results of the test.
2. This DNA test is specific *only for* the condition named above.
3. While mutation and/or linkage analysis often gives precise information, there are several possible sources of error. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, incorrect paternity identification, and sample contamination.
4. The test is complex, may not be FDA approved, and may use some reagents produced for research purposes only. There is always a possibility that a diagnostic error may occur. In addition, the laboratory may have difficulties analyzing my sample and a second sample may be requested.
5. The test may reveal previously unrecognized biological relationships, such as nonpaternity. DNA tests also may reveal a genetic condition in another family member.
6. After the DNA testing of my sample is completed, it may be used anonymously for medical research. **Please circle here: Yes No** Refusal to permit use of my sample for research will not affect this test procedure. I am free to withdraw this consent at any time without prejudice to future care. I can withdraw my consent by calling the laboratory director.
7. There will be a fee for this DNA testing _____ (**initial**).
8. DNA testing may involve emotional stress and may result in discrimination (insurance or work-related). The results of this testing will be treated in the standard medically confidential manner. We are obligated to release test results to your insurance provider if the provider asks for them in order to pay for the test.
9. Follow-up genetic counseling is available. I can contact _____ at _____.
10. I can decide not to receive the results of the test, but I will still have to pay for the test.
11. In the event of physical injury resulting from this procedure the _____ is not able to offer financial compensation or to absorb the cost of medical treatment. However, necessary facilities, emergency treatment and professional services will be available just as they are to the community generally.

NAME OF PHYSICIAN OR GENETICIST:	
Signature of Patient or Legal Guardian:	Signature of Witness:
_____	_____
(date)	(date)