

INFORMED CONSENT FOR GENETIC TESTING

Last Name _____ **First Name** _____

Date of Birth _____ **Gender** Female Male

I request DNA analysis for the condition(s) _____

The intended purpose is: Screening Prenatal Diagnosis Carrier status Predictive

Other _____

I request and authorize ARUP Laboratories to test my (or my child's or my fetus') sample for the above-designated genetic condition. My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional.

1. DNA test results may:
 - a) diagnose whether or not I have this condition or am at risk for developing this condition
 - b) indicate whether or not I am a carrier for this condition
 - c) predict another family member has or is at risk for developing this condition
 - d) predict another family member is a carrier of this condition
 - e) be indeterminate due to technical limitations or familial genetic patterns
 - f) reveal non-paternity
2. This DNA test is specific only for the condition named above and will not detect all causative mutations.
3. The significance of a positive and a negative test result based on my family history has been explained.
4. Although DNA testing usually yields precise information, several sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, and inaccurate information regarding family relationships.
5. DNA testing may cause emotional stress and result in insurance or employment discrimination. All test results are released to the ordering health care provider or those entitled to them by state and local laws.
6. DNA analysis is a fee-for-service test. I will be responsible for payment after the testing has begun, even if I decide not to receive results.
7. Genetic counseling is recommended prior to, as well as following, genetic testing.

Physician:
 I have explained DNA testing and its limitations to the patient or legal guardian and answered all questions.

Printed Name of Physician _____ Date _____

Physician Signature (required) _____ Phone # _____

Physician Fax # _____ Secondary Contact _____