HEALTHLAB

HealthLab
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Informed Consent – Genetic Testing

Patient name: _____ Date of birth: ___/___/_____ SEX: M F

Test(s) ordered: _____

_____

Intended purpose (Please check): ☐ Diagnostic ☐ Carrier status ☐ Prenatal
☐ Screening ☐ Predictive ☐ Other

The Department of Health and Human Services defines genetic testing as "…an analysis performed on human DNA, RNA, genes and/or chromosomes to detect heritable or acquired genotypes, phenotypes, or karyotypes that cause or are likely to cause a specific disease or condition. A genetic test is also the analysis of human proteins and certain metabolites, which are predominantly used to detect heritable or acquired genotypes, mutations, or phenotypes."

Genetic test results are complicated and the implications that may arise from the test results may involve both medical and psychosocial issues as well as result in discrimination (insurance or work related). Therefore, results will only be reported through the referring physician or healthcare professional designated by the physician. All data gathered for the purpose of providing a patient test result will only be used in the reporting process to the requesting physician. We do not release individual patient information without the express written consent of the patient.

Accurate interpretations of the test results are dependent upon the accuracy of the information provided. Be sure to provide your physician with accurate reports of family medical history and biological relationships. Tests may reveal previously unrecognized biological relationships, such as non-paternity or a genetic condition in another family member.

Results and patient information will only be released to the referring physician unless written consent for further distribution is provided or if we are required by law.

I authorize Central DuPage Hospital to submit my sample for testing. 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.

_____ _____
PRINT PATIENT NAME DATE

_____ _____
SIGNATURE RELATIONSHIP TO PATIENT

I, the referring clinician, have reviewed this form with the patient and/or patient's parent or guardian and accept responsibility for pre- and post-test genetic counseling. The person who is the subject of the test or a qualified parent/guardian signed this written consent.

_____
PRINT NAME OF REFERRING PHYSICIAN

_____ _____
SIGNATURE OF CLINICIAN DATE