Informed Consent for Genetic Testing

Patient Name: ______________________

DNA Testing:

As a part of your care, a Genetic Screening Profile is recommended to screen for several common inherited diseases that can be passed on to your baby. The purpose of your DNA test is to look for mutation(s) known to be associated with several common inherited diseases that can occur even without a family history. The Genetic Screening Profile consists of:

- ☐ **Cystic Fibrosis**
- ☐ **Fragile X**
- ☐ **Spinal Muscular Atrophy**
- ☐ **Sequential Screen (Nuchal)**
- ☐ **AFP 4**

1. This testing is done on a small sample of blood and may also include an ultrasound.
2. Mutations are often different in different populations. For the most accurate interpretation of the test results, information about your family history and ethnic background may be requested.
3. When DNA testing shows a mutation, then the person is a carrier or is affected with that condition or disease. Your doctor will consult with you on the results of your test and may recommend a genetic counselor to discuss the full meaning of the results.
4. When the DNA testing does not show a known mutation, the chance that the person is a carrier or is affected is reduced. There is still a chance to be a carrier or to be affected because the current testing cannot find all the possible changes within a gene.
5. In some families DNA testing might discover non-paternity (someone who is not the biological father), or some other previously unknown information about family relationships, such as adoption.
6. The decision to consent to or to refuse the above testing is entirely yours.
7. No test (s) will be performed and reported on your sample other than one(s) authorized by your doctor, and any unused portion of your original blood will be destroyed within 2 months of receipts of the sample by the laboratory.
8. Integrated Genetics will disclose the test results ONLY to your doctor or to his/her agent, unless otherwise authorized by the patient or required by law.
9. Your signature below indicates you have read, or had read to you, the above information and would like to have the Genetic Screening Testing.
10. You have received the Genetic Screening brochure which gives you detailed information about the diseases and carrier risk of the diseases listed above.

No: I DECLINE all genetic testing____

Patient Signature

YES: I REQUEST that the above checked genetic tests will be tested.

____________________________ ____________________________

Patient Signature Date