

PATIENT INFORMED CONSENT FOR DNA TESTING

Patient Name: _____

Date of Birth: _____ Gender Male Female

Name of Referring Physician: _____

Test(s) to be performed: _____

Reason for Testing: Diagnostic Carrier Status / Screening Prenatal
Other _____

The signature on this document constitutes authorization to collect and test samples for the above-designated genetic testing. The signature of the mother, father, or other legally authorized individual, provides authorization to collect and test samples from a child. The signatures also affirm that the benefits, risk, and limitations of this testing have been explained by a health care professional, including but not limited to the following:

1. that the results may diagnose the condition, indicate status as a carrier of the condition, and/or disclose a risks that a family member may develop or be a carrier of this condition.
2. that each party has been informed that there is a small risk associated with the collection of specimens. These risks are as follows:
 - oral swab collection – inflammation of the lining of the mouth
 - blood collection – hematoma or infection
3. that the significance of the results based on family history have been explained.
4. that the U.S. Food and Drug Administration (FDA) has not approved this test, but that approval is not necessary for the use of this test. The results of this test should not be used as the only source of information for clinical diagnosis or patient management decisions.
5. that the test will not detect all mutations possible within this gene nor mutations in other genes. In addition, clinical misdiagnosis may occur due to sample misidentification or inaccurate family history.
6. that participants understand they may ask questions about the collection, testing, or reporting process.
7. that consent is given to use samples for medical research, test validation, or education. Refusal to give consent does not affect the test results.
8. that results will be released only to the ordering physician. Results will be released to a third party only if permission has been submitted in writing by the patient.

I consent to the use of my sample for research purposes as long as my privacy and confidentiality are maintained: Yes No

Signature _____

Date _____

PLEASE ENSURE THE PATIENT READS AND SIGNS THE INFORMED CONSENT and SEND TO MPLN



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