Henry Ford Health System
CENTER FOR PRECISION DIAGNOSTICS

INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)	FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY	PATIENT ID/MRN NUMBER:	
ORDERING PROVIDER INFORMATION (FULL LAST, FIRST): Name: Phone:	GENETIC TESTING REQUESTED FOR: _____ (name of condition) The intended purpose is (check all that apply): ❑ Carrier status ❑ Diagnostic ❑ Predictive ❑ Prenatal ❑ Pre-symptomatic ❑ Screening ❑ Other_____	
SAMPLE TYPE ❑ Amniotic fluid ❑ Blood ❑ Cheek swab ❑ Chorionic villus sample (CVS) ❑ Skin ❑ Tissue block ❑ Other_____		

1. I have been informed about the nature and the purpose of this genetic testing.
2. I have received an explanation of the effectiveness and limitations of this genetic testing.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and I.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. If ordered by the ordering provider above, I authorize supplemental genetic testing to further aid in diagnosis, treatment and/or risk evaluation(s).
7. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
8. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
9. My questions have been answered to my satisfaction.
10. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read this consent form and understand that I can access the booklet electronically at: https://www.michigan.gov/documents/InformedConsent_69182_7.pdf
11. I received a copy of this form for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

_____
Signature of Patient or Authorized Designee Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person: Date: