



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)	
<p style="text-align: center;">SAMPLE TYPE</p> <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Blood <input type="checkbox"/> Cheek swab <input type="checkbox"/> Chorionic villus sample (CVS) <input type="checkbox"/> Skin <input type="checkbox"/> Tissue block <input type="checkbox"/> Other _____	The intended purpose is (check all that apply): <input type="checkbox"/> Carrier status <input type="checkbox"/> Diagnostic <input type="checkbox"/> Predictive <input type="checkbox"/> Prenatal <input type="checkbox"/> Pre-symptomatic <input type="checkbox"/> Screening <input type="checkbox"/> Other _____	

1. I have been informed about the nature and the purpose of this genetic test.
2. I have received an explanation of the effectiveness and limitations of this genetic test.
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 me.
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. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
7. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
8. My questions have been answered to my satisfaction.
9. 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
10. 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: