ADVANCED OBSTETRICS & GYNECOLOGY

"Comprehensive Healthcare for Women"

INFORMED CONSENT FOR GENETIC TESTING

- ☐ SMA (Spinal Muscular Atrophy)
- ☐ Cystic Fibrosis
- ☐ Fragile X
- ☐ Hemoglobinopathy/Hgb Electrophoresis
- ☐ Inherited Hemochromatosis
- ☐ Ashkenazi Jewish Carrier Panel
- ☐ Thrombophilia Panel
- ☐ Beta-Thalassemia
- ☐ Alpha-Thalassemia
- ☐ Muscular Dystrophy
- ☐ PKU (Phenlyketonuria)
- ☐ Sickle Cell Disease
- ☐ _____
- ☐ _____

1. The purpose of the DNA test is to determine whether if a patient has mutation(s) known to be associated with the above genetic disease(s).
2. This testing is done on a small sample of blood.
3. If testing is done to check the genetic status of the infant, testing is done on amniotic fluid or CVS.
4. For most people, if DNA testing shows a mutation, then the person is often a carrier for the disease. Carriers are typically healthy, but are at risk of having a child with significant disease if having a child with another carrier. A discussion with a doctor may be recommended to learn the full meaning of the results and to learn if additional testing might be necessary.
5. 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.
6. Insurance coverage for the testing noted above is variable depending on insurance carriers and/or policy type. It is important that you understand your insurance coverage, as there may be a significant out-of-pocket expense for some or all of the tests.
7. The decision to have genetic carrier testing is optional. It is the patient's decision whether or not to have the test(s) done.

My signature below indicates that I have read, or had read to me, the above information and I understand it. I have also read or had explained to me the specific disease(s) or condition(s) tested for, and the specific test(s) I am having, including the test descriptions, principles, and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with a health care professional. I have all the information that I want and all my questions have been answered. I hereby consent to having this genetic testing performed, and I hereby authorize you to retain the results of this genetic test (and any other genetic test performed by any other physician) in my medical record.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature