

## Informed consent for genetic testing

Surname: \_\_\_\_\_ Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I consent to genetic testing for \_\_\_\_\_ (name of condition)

Clinical indication(s) \_\_\_\_\_

### I understand that:

- The laboratory will not analyze genetic changes not known to be associated with the condition(s) above.
- Current methods may not be able to find all genetic changes associated with the condition(s). Not finding a genetic change does not necessarily rule out the condition(s).
- There is a small chance that the test will not work properly or an error will occur.
- Test results may have implications for children and/or other family members.
- Genetic test results will be reported only through a doctor or genetic counsellor.
- Results are confidential and will only be released to family members or authorities with consent.
- Genetic test results are based on best evidence at the time of reporting.
- Sample(s), including extracted DNA, will be kept for the period required by laboratory guidelines.
- Through a treating doctor, this request may be cancelled or changed before a report is issued.
- With consent (below), sample(s), test results and other relevant information may be used for research studies that have been approved by an Institutional Ethics Committee.

### Results are reported as:

- A genetic change associated with the condition was detected.
- Analysis did not detect any genetic change known to be associated with the condition.
- Genetic changes of unknown significance were found\*.

*\*A genetic change is classified as of unknown significance if there is not enough data at this time to allow interpretation. The significance of the result could change in the future as more information becomes available. Genetic changes of unknown significance will only be reported if requested.*

### Storage and use of the remaining biological material and data:

- I agree that the remaining biological material and data will be stored for possible further analyses.  YES  NO  
*In case of a negative answer the remaining biological sample will be destroyed after the analysis.*
- I agree that my biological sample and data being used anonymously for quality testing  YES  NO
- I agree that my biological sample and data being used anonymously for research purposes  YES  NO

### Patient statement:

My signature below acknowledges that I consent to the genetic testing described above.

Signature: \_\_\_\_\_ Place and date: \_\_\_\_\_  
(Patient or parent/legal guardian)

### Medical statement:

I declare that I have informed the abovementioned person/s as to the potential clinical utility (including risks, benefits and alternatives) of the requested genetic test as well as provide answers to the patient's questions.

Surname: \_\_\_\_\_ Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Place and date: \_\_\_\_\_