



INFORMED CONSENT/REFUSAL FOR aCGH TESTING

I understand that:

- 1) The purpose of this test is to determine if I or my child may have mutation(s) known to be associated with the following genetic condition or disease: _____.
- 2) When DNA testing shows a mutation, then the person is a carrier or is affected with that condition or disease. Consulting a doctor or genetic counselor is recommended to learn the full meaning of the results.
- 3) Except in the case of a known mutation test, a negative genetic test result does not rule out a diagnosis of a predisposition toward, or the ability to pass on, a condition but diminishes the likelihood that the gene being tested is involved.
- 4) This genetic test is specific for the indication for testing and does not test for conditions. Therefore, a negative result does not guarantee my/my child's health.
- 5) In some families, genetic testing might discover non-paternity, or some other previously unknown information about family relationships, such as adoptions.
- 6) The testing process includes highly skilled technicians and advanced technology. Although the method is extremely reliable, as in any laboratory, there is a small possibility that the test will not work properly, or an error
- 7) The decision to consent to, or to refuse, the above testing is entirely mine.
- 8) The lab will make every attempt to report results in the indicated turn-around time but cannot accept responsibility for delays.
- 9) Your results can and/or will be given to your healthcare provider, who will discuss them with you.

YES: I have carefully read and understand the above, have had any questions explained to my satisfaction, and do hereby consent to provide a specimen for testing.

Printed Name of Patient

Printed Name (Patient or Patient's Legal Representative)	Signature	Date
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Witness Printed Name	Signature	Date
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Please Note: Physician may sign this form in lieu of patient if consent has been obtained AND if testing is for diagnostic purposes only.

NO: I refuse to have the genetic testing offered to me. I understand/accept the consequences of this decision

Printed Name of Patient

Printed Name (Patient or Patient's Legal Representative)	Signature	Date
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Printed Name of Witness	Signature	Date
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