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NEUROGENETICS DEPARTMENT – INFORMED CONSENT FOR DNA DIAGNOSTIC TESTS

Name: _____ **Surname:** _____

Date of Birth: ___/___/_____ **Gender:** ☐ **Female** ☐ **Male**

I request DNA testing for the condition: _____

The intended purpose is: ☐ **Diagnostic** ☐ **Carrier status** ☐ **Predictive** ☐ **Prenatal**
☐ **Screening** ☐ **Other:** _____

I request the following tests be performed: _____

_____

I request and authorize the above CING laboratory to test my [or my child's or my foetus] sample for the above-designated genetic condition. My signature below constitutes my acknowledgement that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional.

The following has been explained to me:

1. DNA test results may:
   a. Diagnose whether or not I have this condition or am at risk for developing this condition
   b. Indicate whether or not I am a carrier for this condition
   c. Predict another family member has or is at risk for developing this condition
   d. Predict another family member is a carrier of this condition
   e. Be indeterminate due to technical limitations or familial genetic patterns
   f. Reveal non-paternity
2. This DNA test is specific only for the above-named condition. It will not detect all mutations possible within this gene, nor detect mutations in other genes.
3. The significance of a positive or a negative test result based on my family history has been explained.
4. Although mutation and/or linkage analysis usually yield precise information, several sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, sample contamination, and inaccurate information regarding family relations.
5. DNA testing may cause emotional stress and result in discrimination (insurance or work-related). All test results are treated with standard medical confidentiality.
6. The performance characteristics of this test were validated by the above CING laboratory.
7. My [or my child's or my foetus'] sample may be used for test validation or educational purposes after personal identifiers are removed. Refusal to permit the use of my sample will not affect my test result. For such use the sample may be stored indefinitely. I can withdraw my consent at any time by contacting the laboratory at +357-22392661.

Patient/Guardian Signature: _____ Date: ___/___/_____

Physician/Genetic Counselor:

I have explained DNA testing and its limitations to the patients or legal guardian and answered all questions.

Printed Name of Physician/Genetic Counselor:_____ Date: ___/___/_____

Signature:_____ **Phone number:**_____