



MOUNT SINAI GENETIC TESTING LABORATORY

Department of Genetics and Genomic Sciences
Icahn School of Medicine at Mount Sinai

One Gustave L. Levy Place, Box 1497
New York, NY 10029-6574
Tel: 212-241-7518 Fax: 212-241-0139
www.mssm.edu/geneticstesting
CLIA # 33D0653419

Informed Consent for Genetic Testing

I, _____, hereby request genetic testing for me/or my child (name of child if applicable) _____, which may include molecular, cytogenetic and/or biochemical analyses. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/or my child am about to undergo.

I understand that a specimen(s), such as peripheral blood, dried blood spot, skin biopsy, amniotic fluid, chorionic villi and/or urine sample will be taken from me/or my child. I understand that the samples will be used for determining if I/or my child have a genetic disease, are carriers of a genetic disease or are more susceptible to develop a genetic disease.

The nature of the genetic testing for (disease name) _____

_____ has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

No test will be performed on my sample other than the one(s) authorized by my doctor.

I give consent to have my specimen be used anonymously by the laboratory for the purposes of quality control or for research related to genetic disease. Please check the box below to consent. If you do not consent your sample will be discarded within 60 days of completion of the testing.

I agree to have my sample used anonymously for research by the laboratory. _____

Initials

I understand that this testing may yield results that are of unknown clinical significance and that parental or other relative's specimens may also be tested to determine whether a specific finding was inherited. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated and this test may detect non-paternity.

The results of my/or my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a clinical geneticist.

I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf. I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

Signature of Person Being Tested (or guardian)

Date

Witness

Date