MOUNT SINAI SCHOOL OF MEDICINE

MOUNT SINAI GENETIC TESTING LABORATORY

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Genetic Testing Laboratory
Informed Consent for DNA Testing

I, _____, hereby request DNA based testing for (name of disease)_____. 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 am about to undergo.

I understand that blood samples will be drawn from me and/or members of my family or if prenatal testing is to be performed, fetal cells obtained by amniocentesis, chorionic villus sampling or by fetal blood sampling will be used. I understand that the samples will be used for determining if I and/or my unborn child and/or members of my family are carriers of the disease gene or are affected with or at increased risk to someday be affected with this genetic disease. 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 nature of DNA testing has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that while results obtained from DNA testing are usually highly accurate, infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

I understand that I can seek professional genetic counseling regarding my testing prior to signing this consent. The results of my 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. For prenatal tests, any question of contamination with maternal cells may result in no diagnosis being made and a repeat procedure may be necessary.

I understand that a written report of the test results will be sent to my Physician and the results will only be communicated to my referring Physician and those permitted by law.
The test results will not be released to anyone else without my written consent.

No test will be performed and reported on my sample other than the one(s) authorized by my doctor; and any unused portion of my sample will be discarded within 60 days.

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 if 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