Informed Consent for Chromosome Analysis and/or Fluorescence In Situ Hybridization (FISH) on Blood/Skin Biopsy

I, _______________________________________, hereby request cytogenetic testing for ___________________________________ for me/or my child. 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 cytogenetic testing that I/or my child am about to undergo.

I understand that peripheral blood/skin biopsy samples 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 chromosome abnormality.

The nature of chromosome and FISH analyses 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 chromosome or FISH 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 2 months of completion of the testing.

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

I understand that this testing may yield results that are of unknown clinical significance and that parental or other relatives blood samples may be also be tested to determine whether a specific finding was inherited.

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 ______________

(rev. 9/7/2011)