

# Informed Consent for Genetic Testing

Patient's Name: \_\_\_\_\_

Patient's ID Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Ordering Provider's Name: \_\_\_\_\_

**Note to the Ordering Health Care Provider:** Some states require that patients (or their authorized representatives) provide their written informed consent prior to receiving genetic testing, and that the ordering health care provider maintain documentation of the informed consent in the patient's medical record. This form is intended to assist you with obtaining the patient's informed consent in accordance with applicable law.

As the patient/patient's authorized representative, I understand the following and freely give my consent to this genetic testing:

- **General description and purpose of the test** — My health care provider has recommended that I (or my child) receive the following genetic test: \_\_\_\_\_
- My health care provider has explained that the purpose of this test is to look for mutations or genetic alterations known to be associated with the following genetic disease(s), condition(s), or pharmaceutical therapy: \_\_\_\_\_

I have reviewed information about this specific test and the relevant disease(s) or condition(s) tested for with my health care provider, and my health care provider has explained the test's risks and benefits. (Test-specific information is available on the LabCorp or LabCorp affiliate web site at <https://www.labcorp.com>).

- **Limitations of the test** — This test analyzes specific gene regions and does not rule out the possibility of an undetected variant in other gene regions. Donor DNA from transplants and recent transfusions can lead to inaccurate results. As in any laboratory test, there is a possibility of error.
- **Availability of genetic counseling before and after testing** — I have been provided with information about obtaining genetic counseling prior to giving my consent for this testing. I further understand that my health care provider may recommend consultation with a medical geneticist, genetic counselor, and/or a physician after the testing is completed.
- **Meaning of a positive test result** — A positive test result is an indication that I (or my child) may be predisposed to or have the specific disease(s) or condition(s) tested for. I may wish to consider further independent testing and/or to consult a physician or genetic counselor. I further understand that the ability of genetic testing to provide risk information and the level of certainty associated with a positive test result vary with the type of test. If applicable, I have been provided with information about the level of certainty of a positive result for this test.

- **Meaning of a negative test result** — A negative test result indicates that the clinically significant variant tested was not detected. Negative results may also be due to: (1) maternal contamination of prenatal samples; (2) technical reasons (ie, poor sample quality); and/or (3) the need to test other family members. I have discussed information about the detection rate for the disease(s)/condition(s) with my health care provider and understand that a negative result does not guarantee that I (or my child) will not develop the disease/condition for which testing was performed.
- **Additional acknowledgments concerning the results of prenatal testing** — I understand that normal or negative test results do not guarantee the birth of a child without the specific disease or birth defect for which testing was performed. In addition, a percentage of all pregnancies have birth defects that cannot be detected by testing chorionic villi, amniotic fluid, or by ultrasound examination. In the case of twins or other multiple fetuses, the results may pertain to only one of the fetuses. In the case of abnormal or positive test results, the decision to continue or to terminate the pregnancy is entirely mine.
- **Disclosure of test results** — All tests are confidential and will be disclosed only to the ordering health care provider (or his or her designated representative) unless otherwise authorized by the patient in writing or required by law.
- **Retention of specimens** — No tests other than those authorized by my health care provider will be performed on my (or my child's) sample. The sample will be destroyed at the end of the testing process or not more than 60 days after the sample was taken, unless I expressly authorize a longer period of retention in writing.

Your signature below indicates that you understand to your satisfaction the information about the genetic testing ordered by your health care provider and that you consent to having this testing performed.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative      Date

\_\_\_\_\_  
Relationship to Patient (If the Patient's Authorized Representative)      Date

\_\_\_\_\_  
Signature of Ordering Health Care Provider      Date



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