



## CONSENT FOR GENETIC TESTING

1. I/my child/my fetus (*circle one*) will be tested for genetic indicators that may be linked to the following genetic disease or condition (*insert general description of disease/condition*):

2. The tests have been explained to me. I have discussed with my health care provider the risks, benefits, and limitations of the tests. I have discussed with my provider the reliability and implications of positive, negative or uncertain results. I have discussed with my provider the extent to which a positive test result may predict disease.
3. **Implications for my family:**
  - a. Genetic test results may have meaning for my blood relatives. My health care providers can discuss with me whether and how I might want to share my test results with my family.
  - b. Depending on the situation, the interpretation of genetic test results may depend on the genetic test results of a family member. For this reason, my results (not my actual test report) may be referenced in the records of family members, and the results of family members may be referenced in my records.
  - c. Genetic testing in family members sometimes reveals that true biological relationships are not consistent with reported relationships. For example, misattributed paternity may be detected, which means that the stated father of an individual is not the biological father.
4. The test results will be released by the testing laboratory into my medical record and will be available to my health care providers at Boston Medical Center. The provider who ordered the test will share the results with me. The test results will be a part of my medical record at Boston Medical Center.
5. Genetic counseling, more testing, or additional physician consults may be necessary after testing in order to complete the testing process. Genetic counseling is important and I have been provided with written information identifying genetic counselors or medical geneticists from whom I might obtain genetic counseling.
6. Boston Medical Center will not release information about the results of the genetic testing to anyone else without my express, written consent, except as specifically stated in this consent or required by law.

I have read and understand the above document and have had any questions explained to my satisfaction. I acknowledge that I am the patient or I am the patient's legally authorized representative or surrogate and by signing below indicate that I herein voluntarily consent to the above procedure.

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Patient

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Parent/Guardian/Surrogate (if applicable)

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Provider/Physician/Witness (as applicable)

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

### GENETIC COUNSELING SERVICES AT BOSTON MEDICAL CENTER:

For the most up-to-date information about genetic counseling at Boston Medical Center, please visit:  
<http://www.bmc.org/diagnostic-genetics/services.htm>

\*Please note that genetic counseling may require a referral from your health care provider.\*

To schedule appointments, please call:

**OB-Gyn & Antenatal Services** 617.414.2000

**Oncology** 617.638.1787

**Clinical Genetics (Pediatrics/Adult)** 617.414.4841

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