NewYork-Presbyterian
The University Hospital of Columbia and Cornell

45350

INFORMED CONSENT
GENETIC TESTING

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

Type of specimen: _____

REQUEST FOR MOLECULAR TESTING FOR (Specify all tests that are being ordered) _____

_____

This form must be completely filled out and signed by patient, parent/legal guardian or legal next of kin.

REQUESTING PHYSICIAN _____, M.D. Telephone No. _____ ID Code: _____

CONDITION (Purpose of Testing) _____

In accordance with New York State Law, the following has been discussed with the patient/legal guardian and informed consent obtained. The following was signed in my presence.

Name of person Obtaining Consent _____

Signature: _____ MD/NP/Genetic Counselor Date: ____/____/ 20____

Informed Consent/Advance Beneficiary Notice: **Please read carefully and discuss with your ordering physician/person obtaining consent before signing consent.**

1. The condition stated above has been described to patient/legal guardian in detail.
2. The tests ordered above are for molecular genetic (DNA-based) tests to detect a mutation, or change within gene(s) _____.
3. The patient/legal guardian may wish to obtain genetic counseling prior to signing this consent form in order to understand the testing and what the results may mean. If so, a request should be made to the physician.
4. When DNA testing detects the most common disease-causing changes in a gene, the test result is highly accurate.
5. The results of the testing may 1) indicate a predisposition to have the above specified condition; 2) confirm a clinical diagnosis of the condition; 3) indicate that the patient is a carrier of the condition; 4) or may have uncertain significance.
6. A positive test result will help determine that a patient has the specified condition, or that the patient may develop the condition with a high level of certainty. The level of certainty, if available for the ordered tests, has been discussed with the patient/legal guardian.
7. When DNA testing does not show a known genetic change, the chance that a person is a carrier or is affected is reduced. There is still a small chance to be a carrier or to be affected because current testing cannot find all the possible changes within a gene. The physician will discuss the results with the patient/legal guardian and refer to genetic counseling if indicated or desired.
8. In some families DNA testing may discover non-paternity (someone who is not the real father), or some other previously unknown information about family relationships. This information will be discussed with the patient/legal guardian.
9. The results of the above tests become part of the patient's medical record. They may be made available to individuals/organizations with legal access to the patient's medical records, on a strict "need to know" basis, including, but not limited to the physicians and nursing staff directly involved in the patient's care, the patient's current and future insurance carriers, and others specifically authorized by the patient/legal guardian's authorized representative to gain access to the medical records. Current New York State law prohibits discrimination by insurance carriers based on results of genetic tests.
10. (Initial One)
    - ☐ I authorize
    - ☐ I do **NOT** authorize the staff of the medical genetics staff of New York Presbyterian Hospital to make the results these tests available to the following individuals, family members, or organizations:

    _____

    _____
11. No tests other than the tests specifically authorized above will be performed on this sample, unless specifically authorized by the patient/legal guardian by signing another informed consent. The sample shall be discarded 60 days after analysis in the lab or it may be kept without identifiers and used for control purposes.
12. Advanced Beneficiary Notice: Medicare/Insurance carriers may not pay for the testing, in which case you will be billed for the test.
13. The patient/legal guardian has read and fully understands the above.
    - ☐ I consent to testing as described above. ☐ I decline testing at this time.

Name of Patient: _____

Parent/Legal Guardian: _____ Relationship to Patient: _____

Signature of patient or Parent/Legal Guardian: _____ Date: ____/____/ 20____

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Size: 8.50" x 11.00"
Order Number: _____
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