CONSENT TO OBTAIN A SPECIMEN FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)	FIRST NAME:
DATE OF BIRTH:	HOSPITAL/ ID NUMBER:
ORDERED BY:	GENETIC TESTING REQUESTED FOR: _____ (name of condition)
LABORATORY NAME, CITY AND STATE:	
SAMPLE TYPE ☐ Amniotic fluid ☐ Blood ☐ Saliva or cheek swab ☐ Chorionic villus sample (CVS) ☐ Skin ☐ Tissue block ☐ Other _____	The intended purpose is (check all that apply): ☐ Carrier status ☐ Diagnostic ☐ Predictive ☐ Prenatal ☐ Presymptomatic ☐ Screening ☐ Other _____

1. I have been informed about the nature and the purpose of this genetic test.
2. I have received an explanation of the effectiveness and limitations of this genetic test.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and me.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal incidental or secondary findings- results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
7. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
8. My questions have been answered to my satisfaction.
9. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read both this consent form and the booklet. I received a copy of the form and booklet for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

_____ _____

Signature of Patient or Authorized Designee *Date*

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person: Date:

This consent form was developed by the Michigan Department of Health and Human Services in compliance with PA 29 of 2000 and must be distributed with “Informed Consent for Genetic Testing" patient booklet. Neither may be altered nor deleted to change the meaning of specific statements above or the intent of the informed consent process.