



## Informed Consent/Refusal for Genetic Testing

1. The purpose of this DNA test is to determine whether I (or my fetus if fetal testing is ordered), have mutation(s) known to be associated with the following genetic condition(s):

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2. This testing is done on a small sample of my blood and/or amniotic fluid or chorionic villi obtained from my fetus.
3. Mutations are often different in different populations. I understand that the laboratory needs accurate information about my family history and ethnic background for the most accurate interpretation of the test results.
4. When DNA testing shows a mutation, then the person is a carrier or is affected with the condition or disease tested for. Consulting a doctor or genetic counselor is recommended to learn the full meaning of the results.
5. When the DNA testing does not show a known mutation, the chance that the person is a carrier or is affected with the condition or disease tested for is reduced. There is still a chance to be a carrier or to be affected because current testing cannot find all the possible changes within a gene.
6. In some cases, DNA testing might discover non-paternity (someone who is not the real father) or other previously unknown information about family relationships, such as adoption.
7. In the case of twins or other multiple fetuses, the results may pertain to only one of the fetuses.
8. The decision to consent to or to refuse any of the above procedures/testing is entirely mine.
9. In the case of abnormal prenatal diagnostic results, the decision to continue or to terminate the pregnancy is entirely mine.
10. No test(s) will be performed and reported on my sample other than those authorized by my doctor.
11. My doctor may release my pregnancy outcome and/or ultrasound results to Northwestern Reproductive Genetics to be used for statistical analysis of the laboratory's performance.
12. Northwestern Reproductive Genetics will disclose the test results ONLY to the doctor named below, or to his/her agent, unless otherwise authorized by the patient or required by law.
13. My signature below indicates that I have read, or had read to me, the above information and I understand it. I have had the opportunity to discuss it, including the purposes and possible risks, with my doctor, genetic counselor, or someone my doctor has designated. I know that I may obtain professional genetic counseling if I wish, before signing this consent. I have all the information I want, and all my questions have been answered.

**YES: I REQUEST that Northwestern Reproductive Genetics perform the genetic screening or testing marked above. I understand and accept the consequences of this decision.**

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Patient Signature

Date

Witnessed by

**NO: I DECLINE to have Northwestern Reproductive Genetics perform the genetic screening or testing marked above. I understand and accept the consequences of this decision.**

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Patient Signature

Date

Witnessed by