



5424 Glenridge Drive NE
Atlanta, GA 30342
678.225.0222 FAX 678.225.0212
www.mnglab.com

INFORMED CONSENT FORM FOR DNA TESTING

Patient Name: _____ Date of Birth _____

I/We request and authorize Medical Neurogenetics to analyze a sample of DNA isolated from _____ (sample type) obtained by _____ (procedure) on _____ (date) to assess the probability that I (my/our child) am (is) affected with or carry the gene for the genetic disease _____

ABOUT THE GENETIC TEST

This analysis may have one or more of the following reasons to be of value to your health care: (circle all that apply)

1. To reach a diagnosis for your (child's) disease symptoms
2. To assess your (child's) risk of developing a disease or risk of transmitting the disease to offspring
3. To provide information to help your physician decide on possible therapies
4. To provide information for ongoing research

There are several possible outcomes of this test:

1. The test results may indicate that it is likely or unlikely that I/(my child) am/is affected with or carry the gene for the test.
2. Not all DNA tests are 100% accurate, and the results may be reported as a probability or indeterminate. Rare variations in the DNA of individuals may sometimes cause uncertainty in the interpretation of the results (such as predicting carrier status as a diagnosis).
3. A negative result will exclude the presence of a particular mutation (or mutations) tested for in the tissue that was analyzed. However, it does not exclude the possibility that you (your child) carry other DNA mutations or that a particular mutation is present in tissue other than those that were tested.
4. After the DNA testing is complete, any remaining sample will be stored in the laboratory for two years, after which the DNA sample may be discarded. The DNA will not be released to any institution or individual without your written consent. The DNA may be used at the discretion of the Laboratory Director for research or education purposes under an anonymous label (name and personal identifiers removed).

CONFIDENTIALITY

The result is sent in written form to your physician who will relay the results directly to you so that your questions and concerns can be appropriately addressed. Results will not be given to patients over the phone. This process insures that the information is transmitted directly to your private physician. The results are confidential and will not be released to any institution or individual without your written consent.

CONSENT

My/our signature(s) below constitute acknowledgement that

1. The proposed DNA test(s) and its limitations for my/our specific situation has been satisfactorily explained to me/us, and
2. I/we give my/our authorization and consent for this testing.

Signature (Patient or Legal Guardian)

Date

Witness Signature

Date