INFORMED CONSENT FOR GENETIC TESTING

The purpose of this informed consent is to give you the information necessary for you to determine whether or not to have the genetic testing performed indicated above. The decision to have genetic testing is entirely voluntary. This information includes the benefits, risks, and limitations of genetic testing. Testing for genetic conditions is complex and may warrant professional genetic counseling before giving consent to understand those benefits, risks and limitations.

1. I have been informed about the purpose of this genetic test.

2. I have received an explanation of the limitations of this genetic test including but not limited to:
   a. Not all genetic mutations, defects, or diseases can be detected by genetic testing. Negative results do not guarantee that you or your offspring will be healthy or free of genetic disease.
   b. Some women with normal fetuses will have abnormal screening results.
   c. Abnormal or positive screening results may indicate the need for further testing, such as ultrasound and/or CVS or amniocentesis.
   d. There is the possibility that the findings will be for an abnormality for which the clinical significance is not known or uninterpretable.
   e. Accuracy of genetic testing depends on the type of test ordered, the nature of the condition, and the accuracy of the clinical information provided. Despite the extreme accuracy of genetic testing, no laboratory test is 100% accurate and there is a chance of a false positive or negative result.

3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand that some genetic tests can involve some possible medical, psychological or insurance issues for my family and me including but not limited to:
   a. Genetic testing may reveal sensitive information about your health, your child’s health, or your partner’s health.
   b. If a gene mutation is identified, insurance rates, obtaining disability or life insurance, and employability could be affected. Federal law extends some protections regarding genetic discrimination (http://www.genome.gov/10002328)
   c. Test results may reveal previously unrecognized and unsought biological relationships, such as non-paternity. Non-paternity means that the father of an individual is not the person stated to be the father.

4. I have been informed that because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician, genetic counselor or other identified health care provider. The test results are confidential to the extent allowed by law. They will only be released to other medical professionals and other parties with your written consent or as otherwise allowed by law. Participation in genetic testing is completely voluntary.

5. Additional testing information can be found at www.PAML.com.

6. I hereby authorize the laboratory to furnish my designated insurance carrier information on this form if necessary for reimbursement. I also authorize payment to the laboratory. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services.

7. I understand that my sample will be stored for not more than two (2) months and then will be destroyed.

8. I have read and understand this consent form and have had an opportunity to ask questions about this genetic testing and all of my questions have been answered. I consent and authorize the genetic testing described above.

Patient/Guardian Printed Name

Patient/Guardian Signature

Signature Date (Month DD, YYYY)

Physician/Counselor’s Statement: I have explained genetic testing (including the risks, benefits, and alternatives) to this individual. I have addressed the limitations outlined above, and I have answered this person’s questions to the best of my ability.

Physician/Counselor Signature

Signature Date (Month DD, YYYY)