Informed Consent for Genetic Testing

The purpose of a genetic test is to study your genetic material (DNA) using a molecular-genetic method that has the capability to detect the disease that has occurred or is suspected in you or your family based on changes (called mutations).

Significance of the results:
If a characteristic result in a disease is demonstrated, this result is usually highly conclusive. If no disease-causing mutation is found, genetic changes responsible for the disease may still exist. A genetic disease or tendency to have a disease can therefore not usually be fully excluded.

Sometimes gene variants are proven but their significance is not clear. This is stated in the results and discussed with you. A comprehensive explanation of all possible causes of diseases due to genetic reasons is not possible. It is also not possible to exclude every disease risk for yourself and your family members (especially your children) utilizing genetic analyses. The knowledge of the results may result in mental stress. It is always recommended to discuss the details of the genetic report with your local doctor.

Use of the samples/results:
The sample and the test results will be used for the analysis and in accordance with your consent declaration that is stated below. Any unused portion of the original sample will be destroyed within 1 months of receipt of the sample by the laboratory. The test results will also be used, if possible for treatment decision by your physician(s).

Right of revocation:
You can withdraw your consent to the analysis/examination with effect for the future at any time in full or in part without stating reasons.

Right not to know:
You have the right not to be informed about test results, to stop the testing processes that have been started at any time up to being given the results and to request the destruction of all text/examination results not already known to you.
Genoma Group 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.

The signature below indicates that I have read, or had read to me, the above information and to understand it. I have had the opportunity to discuss it, including the purposes and possible risks, with my doctor 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 Dr._____performs the genetic testing.
I understand and accept the consequences of this decision.

Patient Signature _____ Date_____

Witnessed by_____

☐ **NO: I DECLINE** to have the genetic testing offered to me. I understand and accept the consequences of this decision

Patient Signature _____ Date_____

Witnessed by_____

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