HENRY FORD HEALTH®

Consent for Genetic Testing

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

Office Use Only	
Ordering Provider Information (Last, First) Name: _____ Phone: _____	Genetic Testing Requested for: _____ (name of medical condition)
Sample Type: ❑ Amniotic fluid ❑ Blood ❑ Cheek swab ❑ Chorionic villus sample (CVS) ❑ Skin ❑ Tissue block ❑ Other_____	**The purpose is (check all that apply):** ❑ Carrier status ❑ Diagnostic ❑ Predictive ❑ Prenatal ❑ Pre-symptomatic ❑ Screening ❑ Other_____

I understand and agree to the following:

1. This form goes with an information booklet that has more information on genetic tests. I can find the booklet online at What Michigan Patients Need to Know Before Getting a Genetic Test or a written copy can be provided.
2. This genetic test has been explained to me. I understand why I am having this test done.
3. I understand what this genetic test may or may not be able to find.
4. I was able to talk to my doctor or other health care provider about the benefits and the risks of this test. I know that some genetic tests can involve health, mental health, or insurance issues for me or my family.
5. I understand what the results may mean and how I will get them.
6. I understand that genetic tests can sometimes find other results that have nothing to do with the original reason for the test. These are called secondary findings. I talked to my doctor or health care provider and I understand that I can decide if I want secondary findings shared with me.
7. I was told who may access my sample. I understand that any leftover sample may be kept by the laboratory and used for quality checks.
8. I was told who may see my test results. These results will be part of my health record.
9. I was able to talk to my doctor and have my questions answered about this test.
10. I was given a copy of this form for my records.

I have read this form, or it was read to me. I understand and agree to what it says. I agree to have a sample taken for genetic testing for the condition(s) listed above. If the signer is not the patient, the signer confirms that they are the patient's legally authorized representative.

Person signing form (circle one): Self Parent(s) Legal Guardian Durable Power of Attorney for Health Care

_____ _____ _____

Signature of Patient or Authorized Designee Time Date

_____ _____ _____

Signature of Physician or person explaining information Time Date