BRIGHAM AND
WOMEN'S HOSPITAL

75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

**Clinical Cytogenetics Laboratory:**

**Cytogenetic Testing Consent**

I understand the following:

1. Having this testing is my choice and I have the right to refuse being tested.

2. I must give consent before testing is done for the purpose of identifying changes in genetic material (DNA or chromosomes). This can be performed before or after an individual is born.

3. The purpose of each test, including a description of the disease or condition for which the test is being requested, has been explained to me.

4. I have discussed the uses and limits of each requested test with my medical provider (i.e., what does a positive, negative, or uncertain test result mean?).

5. A false positive or negative test result may occur and additional testing may be needed to confirm or refine the interpretation of test results.

6. Errors in diagnosis may occur in family genetic studies if the true relationship of the family members is either unknown or is not as stated. Genetic testing may suggest that a man is not the father of a child, and it may be necessary to get another sample and/or report this finding to the requesting physician.

7. Genetic counseling is important and is available to me. I understand that genetic counseling is available to me through my health care provider, who may also choose to refer me directly to a genetic counselor.

8. My sample may be sent, by the BWH Clinical Cytogenetics Laboratory, to another approved laboratory for testing if the BWH Clinical Cytogenetics Laboratory cannot perform the requested test.

9. A record of the testing performed, including the results, will be entered into my hospital record, including the hospital's electronic medical record. These results are confidential. I understand that authorized BWH personnel can view these results and will report them to my medical provider, according to BWH policy.

10. I have been given a chance to ask questions about the ordered tests, and I have been told how I will receive results.

11. Upon completion of the testing, a part of my sample may be de-identified (information related to me will be removed) and used for internal laboratory quality assurance or for research purposes.



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Patient Agreement: I give permission for the BWH Clinical Cytogenetics Laboratory, or a laboratory my provider has chosen, to perform the genetic test(s) indicated:

Specimen type: _____

Test(s) requested: _____

_____ _____ _____ AM/PM
Patient/Surrogate Decision Maker Signature Date Time

_____ _____
Patient Name (Print) Surrogate Decision Maker Name if applicable (Print)

___ Other
GC
NP
PA
_____ MD CID | | | | | | _____ _____ AM/PM
Signature Date Time