swissdnalysis
step up your quality of care

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Patient Name:

Date of Birth:

Gender:

Address:

Insurance:

Genetic Test Informed Consent

I confirm that in the context of a genetic counselling session I have been informed about the different aspects of genetic testing as explained in the information sheet “Information for Patients”. I have understood the information and had sufficient time for decision making.

1. **I give my consent to perform the following genetic analysis/es:**

_____

2. **For the following disorder/es:**

_____

3. **A copy of the genetic test results should be sent to:**

_____

4. **I want to perform this test even if my insurance denied the payment** (max. CHF_____)

☐ Yes ☐ No

5. **I would like to be informed about the results of the genetic clarification regarding the above question**

☐ Yes ☐ No

6. **The following question should not be answered if a single mutation will be tested.**
I have been informed that incidental findings can ocurr. This are **results not related to the test requested above.**

☐ **I want to be informed about incidental findings as follows:**

If I am carrier of a disorder for which preventive and/or therapeutic measures are available ☐ Yes ☐ No

If I am carrier of a disorder for which preventive and/or therapeutic measures are **not** available ☐ Yes ☐ No

If I am a healthy carrier of a recessive disorder ☐ Yes ☐ No

☐ **I don’t want to be informed about incidental findings**

7. **I give my consent to**

Store my sample for future test (on my interest and with my request) ☐ Yes ☐ No

Use my sample for quality control ☐ Yes ☐ No

Use my sample and data for research questions (including any subsequent publication of anonymised data in scientific journals) ☐ Yes ☐ No

Signature: _____ Place and date: _____
(Patient or parent/legal guardian)

Medical Counsellor:
I declare that I have informed the above mentioned person about the planned genetic tests and their limits as well as providing answers to the patient questions.

Signature: _____ Place and date: _____
(Name and Stamp of Physician)