Delaware Valley Institute of Fertility & Genetics
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INFORMED CONSENT/REFUSAL FOR GENETIC TESTING

1. I am a patient of the Delaware Valley Institute of Fertility & Genetics (hereinafter DVIFG).
2. I understand that DVIFG seeks to perform certain genetic DNA tests to look for mutations, specifically autosomal recessive or x-linked genetic conditions. Mutations are often different in different populations. I understand that DVIFG needs accurate information about my family history and ethnic background.
3. When DNA testing demonstrates a mutation, the person is a carrier or is affected with that condition or disease. Consulting a doctor or genetic counselor is recommended to understand the full implications of the results.
4. When the DNA testing does not show a known mutation, the chance that the person is a carrier or is affected is reduced. **There is still a risk to be a carrier or to be affected because current testing cannot find all the possible changes within a gene.**
5. In some families, DNA testing might discover non-paternity (someone who is not the biological father) or some other previously unknown information about family relationships, such as adoption.
6. The decision to consent or refuse to consent to the genetic DNA testing is entirely mine.
7. DVIFG will not perform any test except the ones authorized by my doctor. Any unused portion of my original sample will be destroyed within 2 months of receipt. DVIFG 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.
8. My signature below indicates that I have read, or have read to me, the above information. I understand it. I have had the opportunity to discuss this information, including the purposes and possible risks, with my doctor or someone my doctor designated. I understand that I may obtain professional genetic counseling if I wish before signed this consent. I have all the information I want. All of my questions have been answered.

____ **YES** I REQUEST that DVIF&G performs the genetic testing. I understand and accept the consequences of this decision.

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

Date:_____ _____ _____
Print Patient Name Sign Patient Name

Date:_____ _____ _____
Print Witness Name Sign Witness Name

Edited 3/7/2018