Clinic *for* Special Children

535 Bunker Hill Road, P.O. 128,
Strasburg, Pennsylvania 17579
P 717.687.9407 F 717.687.9237
www.clinicforspecialchildren.org

Informed Consent for Molecular Genetic Testing

Patient				CSC ID number	
Address					
City		State		Zip	
Telephone		Birthdate			
Spouse					
Father		Mother			
Paternal grandparents					
Maternal grandparents					

Genetic test(s) requested (see list):

Disease

Gene

Mutation

☐ DNA storage

☐ Research

The diagnosis of a genetic disease or the identification of people at risk for having a child with a genetic disease requires the testing of DNA for the presence of an abnormal gene.You and/or your physician are requesting the Clinic for Special Children to perform a genetic test on you or your child. The purpose and accuracy of this test has been explained to you and your questions have been satisfactorily answered.

Development and performance of this testing was determined by the Clinic for Special Children. This clinical testing has not been approved by the FDA; however, the FDA has determined that such approval is not necessary. Some reagents used in this testing are produced for research purposes only. There is always a chance that an error may occur (including, but not limited to, sample contamination and sample misidentification). A negative test result does not necessarily exclude a genetic disease. Results of genetic testing should be considered with the results of other laboratory testing as well as clinical evaluation. The results of these tests will be handled in the standard medically confidential manner.

You and/or your physician acknowledge permission to (1) obtain about 3 mls of blood from a vein in your arm, (2) isolate DNA from this sample, (3) perform the requested diagnostic tests (if any), and (4) store the DNA sample at the Clinic for Special Children. DNA samples remaining after diagnostic testing may be used further for quality-control purposes.

Signed: _____ Date: _____
Patient/Legal guardian

Alternate consent: I, the health care provider requesting the above testing, have explained the benefits and limitations of genetic testing to the patient and/or their legal guardian and have received verbal consent to order genetic testing.

Signed: _____ Date: _____
Health care provider

Revision 2/1/2008

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Laboratory Requisition Form

Section A

Patient:	Birthdate:

Section B

Sample:	☐ Venous blood	☐ Serum/plasma	☐ Filter paper	☐ Urine
	☐ Cord blood	☐ Other _____		

Section C

Tests:

- ☐ Amino acid quantitation by HPLC
- ☐ Organic acid analysis by GC/MS
- ☐ Targeted mutation detection * (see Mutation List)

Disease

Gene

Mutation

* All molecular genetic testing MUST be accompanied by signed consent forms.

Section D

Referrer:	☐ Physician	☐ Midwife	☐ Genetic counselor	☐ Other
Name:				
Institution:				
Address:				
City:		State:	Zip:	
Telephone:		Fax:		
Reporting: Please provide **one** address and/or fax number for test reporting.				
Name:				
Institution:				
Address:				
City:		State:	Zip:	
Telephone:		Fax:		
Billing: Please provide an address for billing purposes (if different from **Reporting**, above).				
Name:				
Institution:				
Address:				
City:		State:	Zip:	
Telephone:		Fax:		

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