**Arkansas Children's Hospital**
**Genetics**
**Consent – Genetic Testing**

Patient Name: _____ Date of Birth: _____

**Clinical Features:** 1. _____
2. _____
3. _____

**Please send completed form with sample or fax to 364–1733**

**Genetic Test(s) Requested:** 1. _____
2. _____
3. _____

**Reflex if negative:** ❑ **Yes** ❑ **No**

I request and authorize Arkansas Children's Hospital to test my (or my child's) sample for the above–designated genetic condition or features. I understand the following benefits and limitations to DNA testing, and they have been explained to me:

1. DNA testing is voluntary and results may:
   a) **diagnose whether or not I/my child has this condition or is at risk for developing this condition**
   b) **indicate whether or not I/my child is a carrier for this condition**
   c) **reveal unintended health information not related to this condition**
   d) **predict another family member has or is at risk for carrying/developing this condition**
   e) **be indeterminate due to technical limitations or familial genetic patterns**
   f) **reveal family relationships including non–paternity and the degree to which parents may be related**
2. This DNA test may be specific only for the condition/indication named above. It will not detect all mutations possible.
3. The meaning of a **positive**, **negative**, or a **variant of uncertain significance** as a test result has been explained based on my family history.
4. Although genetic testing methods of this lab have been validated and usually yield precise information, sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, insufficient sample, and inaccurate information regarding family relationships.
5. All test results are treated with standard medical confidentiality. Though legislation is in place to protect patients from discrimination based on genetic information applying to current insurance coverage– life insurance and disability insurance are still impacted by genetic information. If an insurance provider requires test results for reimbursement purposes, the laboratory is obligated to release them.
6. DNA analysis is a fee–for–service test. **Testing prices and information are available by contacting 501–364–1316.** Commercial insurance will be billed and I may be responsible for remaining payment.
7. Results of DNA testing should be conveyed by the medical professional(s) ordering this testing or a Genetics medical professional, and **Genetic counseling** is recommended for anyone receiving genetic testing.

Signature of Parent/Guardian _____ Date _____ Time: _____

**Physician's/Counselor's statement:** I have explained DNA testing to this individual. I have addressed the limitations outlined above and have answered all questions. A copy of this form may be requested by the patient or guardian.

Signature of Witness _____ Date _____ Time: _____
(i.e. Physician or Counselor)