CONSENT FOR GENETIC TESTING

1. My child/my fetus (circle one) will be tested for genetic indicators that may be linked to the following genetic disease or condition (insert general description of disease/condition):

2. The tests have been explained to me. I have discussed with my health care provider the risks, benefits and limitations of the tests. I have discussed with my provider the reliability and implications of positive, negative or uncertain results. I have discussed with my provider the extent to which a positive test result may predict disease.

3. Implications for my family:
   a. Genetic test results may have meaning for my blood relatives. My health care providers can discuss with me whether and how I might want to share my test results with my family.
   b. Depending on the situation, the interpretation of genetic test results may depend on the genetic test results of a family member. For this reason, my results (not my actual test report) may be referenced in the records of family members, and the results of family members may be referenced in my records.
   c. Genetic testing in family members sometimes reveals that true biological relationships are not consistent with reported relationships. For example, misattributed paternity may be detected, which means that the stated father of an individual is not the biological father.

4. The test results will be released by the testing laboratory into my medical record and will be available to my health care providers at Boston Medical Center. The provider who ordered the test will share the results with me. The test results will be a part of my medical record at Boston Medical Center.

5. Genetic counseling, more testing, or additional physician consults may be necessary after testing in order to complete the testing process. Genetic counseling is important and I have been provided with written information identifying the name of a genetic counselor or medical geneticist from whom I might obtain genetic counseling.

I have read this form and I understand it. I may keep a copy for my records.

Name of patient (printed): __________________________
Name of person providing consent, if not patient (for example, parent): __________________________
Signature of person providing consent: __________________________
Date and time: __________________________

STATEMENT OF PROVIDER ORDERING THE GENETIC TEST
I certify that appropriate written consent has been obtained from the patient or their legal surrogate decision-maker.

Name of provider ordering the test: __________________________
Signature of provider ordering the test: __________________________

PATIENT HANDOUT - GENETIC COUNSELING SERVICES AT BOSTON MEDICAL CENTER
For the most up-to-date information about genetic counseling at Boston Medical Center, please visit:
http://www.bmc.org/diagnostic-genetics/services.htm

*Please note that genetic counseling requires a referral from your health care provider.*

OB-GYN & Antenatal Services
Katherine Krepkovich, MS, MS, CGC, (genetic counselor)
MaryAnn Campion, MS, CGC, (genetic counselor)
To schedule appointments, please call 617.414.2000.

Oncology
Maureen Flynn, MS, MPH, CGC – Genetic Counselor
To schedule appointments, please call 617.638.5908.
Referrals can be faxed directly to 617.638.5909.

Pediatrics
Developmental and Behavioral Pediatric Clinical Programs
Marilyn Augustyn, MD, Division Director
Associate Professor of Pediatrics, Boston University School of Medicine, Boston MA
Developmental and Behavioral Pediatrician

Amyloidosis Center
For more information, please call: 617.638.4317

Hematology
Center of Excellence in Sickle Cell Disease
Hematology Diagnostic Reference Laboratory
For more information, please call: 617.414.1024.