COHESION PHENOMICS

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Informed Consent for Genetic Testing

I consent to participate in genetic testing for:

I have read the test specific information at www.CohesionPhenomics.com. I agree to submit my sample for testing as recommended by my physician. I understand that a biological specimen (blood, saliva, tissue) will be obtained from me and/or members of my family. I am aware that the physical risk of testing is minimal.

The results of this test may

- Confirm my diagnosis
- Predict the chance of developing a disease in the future
- Determine my chance of passing the disease to my children

It has been explained to me and I understand that

- A positive result is an indication that I may be predisposed to, or have the specific disease. Further testing may be needed to confirm the diagnosis.
- Limitations in the current technology and/or incomplete scientific knowledge of genes may yield a negative test result. There is a chance that I will have the disease in spite of a negative result.
- It may be likely that the test findings are of unknown clinical significance. Additional testing for me and/or my family members may be recommended to understand the relevance of the result.
- In some rare cases, test findings reveal or suggest conditions different than that was initially contemplated.

The accuracy of genetic testing depends on the test ordered, the nature of the genetic condition, the accuracy of clinical information provided and correct family history. Genetic testing is highly accurate, but there are limitations.

- An error in test interpretation may occur if the true biological relationships in the family are not as stated. On rare occasions, testing may obtain results suggestive of non-paternity and it may be necessary to report this to the ordering physician.
- Genetic tests are continually being improved upon to identify more mutations. Testing is a highly complex process and there is always a small possibility that the test will not work properly or that an error has occurred.
- Even though all certified laboratories have very stringent rules for handling samples, errors can occur with sample labeling, sample contamination or misinterpretation of laboratory findings.

The laboratory does not discard patient DNA samples after testing, as it is possible to perform additional studies with these samples. The DNA samples can be used as controls or in test development efforts.

The referring physician or other authorized healthcare professional must request additional testing. Samples will be retained in the laboratory in accordance with the laboratory retention policy. I understand that I have the right to withdraw this consent at any time, and the entity storing the sample shall promptly destroy the remaining sample.

Initial	

Test results are confidential

- Test results will be reported only to the referring physician, genetic counselor, or other identified health provider.
- Test results will not be released to others without my written consent. All laboratory raw data are confidential and will not be released unless a valid court order is received.
- The test results may be part of my medical record and thus accessible to my health insurance provider or other parties within legal limits.
- I understand that my test results may impact the clinical or reproductive decisions of my family members.
- I understand that I may obtain genetic counseling prior to signing this consent form. I may also wish to consider further independent testing, consult my physician if I have a positive test result.
- I am aware that having a positive test result could qualify me to enroll in research studies, which may lead to new treatments.

PATIENT SIGNATURE

My signature below acknowledges my voluntary participation in this test. I understand that the genetic analysis performed at Cohesion Phenomics is specific only for this disease and in no way guarantees my health, the health of my unborn child or the health of other family members.

Patient Printed Name	X	**Birth Date**	
Patient Signature	X	**Date**	
Witness Signature	X	**Date**	

PHYSICIAN OR COUNSELOR'S STATEMENT AND SIGNATURE

I have explained genetic testing (including the risks, benefits, and alternatives) to my patient. I have addressed the limitations outlined above, and I have answered this person's questions to the best of my ability. I have obtained consent from the patient or the legal guardian for this testing.

Physician Signature	X	**Date**	
Printed Name	X	**Phone #**	