MAYO CLINIC
Mayo Medical Laboratories

Cystic Fibrosis Screening Informed Consent and Patient History Form

Patient Information

Patient Name (L,F,M)	*Birth Date*	*Gender*
Physician/Genetic Counselor	*Phone*	*Fax*

Reason for Testing

- □ CARRIER SCREEN- Check appropriate box
  - □ Clinically normal individual with no family history of the condition
  - □ Family history of the condition
  - □ Spouse has family history of the condition
  - □ Spouse is a carrier of the condition
  - □ Anonymous egg or sperm donor
- □ DIAGNOSIS OR SUSPECTED DIAGNOSIS _____

Ethnic Background

□ Northern European Caucasian	□ Hispanic	□ Ashkenazi Jewish	□ Southern European Caucasian
□ Mixed European Caucasian	□ Asian	□ French Canadian	□ African American
□ Caucasian – Indicate countries of origin: _____		□ Other (specify)_____	

Pregnancy Information

Is the patient currently pregnant? □ *No* □ *Yes If yes, how many weeks gestation?*_____

Family History

Are other relatives known to be affected? □ No □ Yes If yes, indicate their relationship to the patient_____
Are other relatives known to be carrier? □ No □ Yes If yes, indicate their relationship to the patient_____
Have other relatives had molecular genetic testing? □ No □ Yes If yes, complete the information below
Gene:_____ Name and date of birth of individual tested:_____

Mutations:_____ _____ Laboratory at which testing was performed:_____

Informed Consent for Genetic Testing

Testing for genetic conditions can be complex. If warranted, obtain professional genetic counseling prior to giving consent to fully understand what the risks and benefits are to having the testing completed. I hereby consent to participate in testing for CYSTIC FIBROSIS using a genetic test. I understand that a biologic specimen (blood, tissue, amniotic fluid, or chorionic villi) will be obtained from me and/or members of my family. I understand that this biologic specimen will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease.

It has been explained to me and I understand that:

This test is specific for CYSTIC FIBROSIS MUTATION TESTING

- □ A positive result is an indication that I may be predisposed to or have the specific disease, or condition. Further testing may be needed to confirm the diagnosis. I understand I will be given the opportunity to talk with my physician or a genetic counselor about these results.
- □ There is a chance that I will have this genetic condition but that the genetic test results will be negative. Due to limitations in technology and incomplete knowledge of genes, some changes in DNA or protein products that cause disease, may not be detected by the test.
- □ There may be a possibility that the laboratory findings will be uninterpretable or of unknown significance. In rare circumstances, findings may be suggestive of a condition different than the diagnosis that was originally considered.
- □ In many cases, a genetic test directly detects an abnormality. Molecular testing may detect a change in the DNA (mutation). Cytogenetic testing may identify whether there is extra, missing or rearranged genetic material. Biochemical methods are sometimes used to look at abnormalities in the protein products that are produced by the genes. Most tests are highly sensitive and specific. However, sensitivity and specificity are test dependent.
- □ When a direct test is not available, the laboratory may use a method called linkage analysis. Linkage analysis is not as accurate as a direct test, but will report the probability that you or a family member have inherited a disease or disorder. In some families, the markers used in linkage analysis may not be informative. If this is the case, the DNA test cannot provide results for that family, or for some members of that family.
- □ The accuracy of the test depends on correct family history. An error in diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated. In addition, testing may inadvertently detect non-paternity. Non-paternity means that the father of an individual is not the person stated to be the father.
- □ An erroneous clinical diagnosis in a family member can lead to an incorrect diagnosis for other related individuals in question.
- □ The tests offered are considered to be the best available at this time. This testing is often complex and utilizes specialized materials. However there is always a small chance an error may occur.
- □ Because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician, genetic counselor, or other identified health care provider. The results are confidential to the extent allowed by law. They will only be released to other medical professionals or other parties with my written consent or as otherwise allowed by law. Participation in genetic testing is completely voluntary.
- □ I understand that Mayo Medical Laboratories is not a specimen banking facility and my sample will not be available after 60 days or for future clinical studies. I understand that my specimen will only be used for the genetic testing as authorized by my consent and that my sample will not be used in any identifiable fashion for research purposes without my consent.

Signatures: *My signature below acknowledges my voluntary participation in this test. I understand that the genetic analysis performed by Mayo Medical Laboratories is specific only for this disease and in no way guarantees my health, the health of an unborn child, or the health of other family members.*
I indicate my desire to opt out of participation in anonymized research studies using my DNA sample by initialing here____ . All samples from New York clients will be disposed of 60 days after testing is complete. Receipt of this document ensures that my specimen will be destroyed upon completion of the testing for which it was obtained.

Patient Printed Name Patient SIgnature Signature Date (MM/DD/YYYY)

Physician/Counselor Statement: I have explained genetic testing (including the risks, benefits, and alternatives) to this individual. I have addressed the limitations outlined above, and I have answered this person's questions to the best of my ability.

Physician or Counselor Signature Signature Date (MM/DD/YYYY)