PATIENT LABEL

GENETIC INFORMED CONSENT FORM

LABORATOIRE NATIONAL DE SANTE
NATIONAL CENTER OF GENETICS
1, rue Louis Rech
L-3555 Dudelange
Formulaire disponible sous www.lns.lu

CERTIFICATE OF INDIVIDUAL MEDICAL CONSULTATION

I, undersigned _____Doctor in Medicine / Genetic Counsellor under the responsibility of Doctor _____certify that I have received the patient in consultation. The purpose of this consultation is to provide the patient with information on the characteristics of the disease under investigation, the means of diagnosing it, possibilities of prevention and treatment, the possibility that genetic characteristics not directly related to the prescription are identified, the limits of the genetic testing methods proposed to him/her and the right to know or refuse to know his or her results.

GENETIC CONDITION or GENETIC TEST

_____

CONSENT

By signing below, I consent to the genetic testing (as indicated on the test request form or detailed above):

☐Performed on myself

☐Performed on my child/fetus

This testing is carried out to determine the genetic cause of the clinical condition described above. I hereby confirm that the requesting physician has informed me in detail about:

- The medical necessity of the planned genetic test.
- The potential benefits and limitations of the test.
- Possible consequences due to the communication of results, including potential psychological consequences.

With your consent, **unused sample material** will be stored. Please decide if and how unused sample material may be used. I consent to the use of this material - For laboratory quality assurance and future diagnostic investigations. - For the purposes of academic teaching and scientific research.	 ☐ Yes ☐ No ☐ Yes ☐ No
I consent to being informed of **secondary/additional findings**[1],[2] if these have direct medical implications (e.g. possible prophylactic measures or therapeutic consequences) or may constitute a significant genetic risk for me or my family members. [1] According to current scientific understanding and expert society recommendations. [2] Variants that may be obtained incidentally during the course of genetic testing and are associated with a condition other than the one for which testing was originally indicated.	☐ Yes ☐ No
If necessary, I consent that my sample material, my personal data and the test request is **forwarded** to a specialized cooperating laboratory or institute in order to investigate the above-stated condition in question.	☐ Yes ☐ No
I consent that data and test results collected in the context of the condition in question may be used in de-identified (pseudonymized) form for **scientific research**[1] and published in anonymized form in medical journals. [1] e.g. to improve the understanding of the molecular pathogenesis and develop new diagnostic or treatment possibilities)	☐ Yes ☐ No
I consent that my test results may be used for the purpose of counseling and testing of at-risk family members	☐ Yes ☐ No

I understand that I have the right to withdraw from the procedure at any time and request the destruction of my sample without providing any justification. In such an event, I will notify the prescribing doctor in writing.
I acknowledge that my consent applies to both myself and/or my minor child(ren). I am aware that I can withdraw this consent at any time, either verbally or in writing, without the need to provide reasons.

Date _____ , Place _____

Patient: Name & signature or the legal representative of the minor child or the legal guardian of the adult under guardianship	2nd legal representative (if needed): Name & signature	Prescriber: Name & signature