

INFORMED CONSENT AND RELEASE FOR GENETIC THROMBOPHILIA TESTING

I, \_\_\_\_\_, hereby request and authorize **Dr.** \_\_\_\_\_ and associates to perform blood testing on me in order to detect genetic thrombophilia.

It has been explained to me and I understand that:

1. These procedures involve a small risk of bruising at the site of blood drawing.
2. These tests involve genetic testing (my DNA make up) and are performed in order to detect whether I have any gene mutation (altered gene) that may increase my ability to clot (thrombophilia).
3. I understand that most of these genetic abnormalities are inherited from my biological parents but some times these defects may happen as a result of a new mutation (de novo mutation) that is not present in my parents but only in me.
4. I understand that these genetic conditions may be transmitted to my unborn child and as a result, may affect the pregnancy outcome. When indicated, we may ask to test the father of the baby for genetic thrombophilias in order to improve the treatment success of the unborn.
5. When the results are negative, they do not exclude the presence of Thrombophilia because there is a large number of genetic thrombophilias that cannot yet be detected by genetic testing.
6. In some families, genetic testing might discover non-paternity (someone who is not the real father), or some other previously unknown information about family relationships, such as adoption.
7. The office of Dr. \_\_\_\_\_ **does not guarantee** that this screening will be covered by your insurance. I understand it is entirely my responsibility either to pay the charges myself and/or to contact my insurance carrier to determine if this testing will be covered.

I have read, or had read to me, the above information and I understand it. I have had an opportunity to discuss it, including the purpose and possible risks to me and to my unborn baby, with my doctor or with someone my doctor has designated. I have received all of the information I want. All my questions have been answered.

Signed: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

I consent to the use of any remaining fluid for additional studies relating to this pregnancy or for the purpose of research in prenatal diagnosis.

Signed: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Interpreter if necessary: \_\_\_\_\_

I do not wish to have genetic thrombophilia testing at this time.

Signed: \_\_\_\_\_ Witness: \_\_\_\_\_