



UMassMemorial

Laboratories

Genetics Testing & Consent

UMASS Memorial Medical Center, Inc., Worcester, MA 01605
For a list of Patient Service Centers visit
www.umassmemoriallabs.org
or call Customer Service: 800-476-4431

BARCODE LABEL

PATIENT INFORMATION table with fields: COLLECTION DATE, COLLECTION TIME, PATIENT LAST NAME, FIRST, M.I., DATE OF BIRTH, ADDRESS, CITY, STATE, ZIP, SOC. SEC #, TELEPHONE#, Male/Female checkboxes.

With my signature below, I give permission for UMMMC Department of Hospital Laboratories, or their referral laboratory, to perform the genetic test(s) indicated:

Specimen: \_\_\_\_\_ Date Collected: \_\_\_\_\_

Test(s): \_\_\_\_\_

I understand the following:

- 1. This test is voluntary and I have the right to refuse being tested.
2. I must provide informed consent before diagnostic testing is performed for the purpose of identifying genes, inherited or acquired genetic abnormalities, or the presence or absence of inherited or acquired characteristics in genetic material (DNA, RNA, chromosomes, or proteins).
3. The purpose of each test has been explained, including a description of the disease or condition for which the test is being requested.
4. I have discussed the uses and limitations of each requested test (i.e. what do positive or negative test results mean?) with my Medical Practitioner.
5. A false positive or negative test result may occur, and additional testing may be needed to confirm or refine the interpretation of test results.
6. Errors in diagnosis may occur in familial genetic studies if the true biological relationship of the family members is either not known or as stated. Genetic testing may suggest non-paternity and it may be necessary to obtain another sample and/or report this finding to the requesting physician.
7. Genetic counseling is important and is available to me. I understand that genetic counseling is available to me through the UMMMC Genetics Service (508-856-3949) or:
8. My specimen may be forwarded, by the UMMMC Department of Hospital Laboratories, to another accredited laboratory for testing if the UMMMC laboratories cannot perform the requested test.
9. A record of the testing performed, including the results, will be entered into my hospital record, including the hospital's electronic medical record. These results are confidential. I understand that authorized UMMMC personnel can view these results and they will be reported to my Medical Practitioner according to UMMMC policy. The charges for this testing, with an indication of the testing performed, will be submitted to my health care insurer.
10. I have been given the opportunity to ask questions about the ordered tests and told how I will get the test results.
11. Upon completion of testing, a portion of my specimen may be made anonymous and used for test validation or research purposes. Once the material has been made anonymous, its original source can no longer be identified.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE