Scannez-moi
Scan mich
Escaneie-me

PATIENT CONSENT AND MEDICAL CONSULTATION CERTIFICATE

INDICATIONS

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PATIENT

Married name

Surname

Forname

Date of birth

CNS N°

INFORMED CONSENT

I have been informed

- Of my right to withdraw consent at any time, with no need to justify my decision.
- Of my right not to be informed of the test results.
- Of my right to stop the tests initiated at any time before the results are communicated and of my right to require the destruction of all my samples (including extracted nucleic acids) and the results obtained.

With your consent, your unused biological samples will be stored. • I agree that they may be used to verify the results obtained, for subsequent testing and as part of the quality assurance work of the laboratory. • I agree that they may be used for the purposes of research or as part of university education.	Yes ☐ No ☐ Yes ☐ No ☐
I consent to be informed[1] of any secondary/additional results[2] if they have direct medical implications (e.g. possibility of preventive measures or therapeutic consequences) or may present a significant genetic risk for me or my family members. *[1] Based on current scientific knowledge and the current recommendations of the American College of Medical Genetics and Genomics (ACMG).* *[2] Variants that may be obtained accidentally during a genetic test and related to a condition other than that for which the test was initially indicated.*	Yes ☐ No ☐
(If necessary), I agree that my sample, my personal data and the test request may be sent to a participating laboratory or institute for the purpose of testing for the aforementioned disease.	Yes ☐ No ☐
I agree that the data and test results collected as part of the management of the condition in question may be used in an anonymised form for scientific research[1] and published in anonymised form in medical journals. [1] e.g. in order to improve the understanding of the molecular mechanisms of the disease and/or in order to develop new possibilities of diagnosis or treatment)..	Yes ☐ No ☐
I consent to my personal data and test results being stored beyond the legal ten-year storage period.	Yes ☐ No ☐
I agree that my test results may be used for genetic counselling and to test my family members who are potentially at risk.	Yes ☐ No ☐

By signing this consent form, you confirm that the responsible medical personnel have informed you of the importance and consequences of the planned genetic tests. Further, you have been clearly informed of the medical necessity and potential benefits of genetic testing. Any risk for the health that may result from the collection of biological samples and the communication of the test result (such as psychological stress) have been discussed in detail.
The result of this test will be presented and explained to me by the prescribing doctor (or by delegation to the genetics counsellor) based on the current state of knowledge in the context of a genetic consultation.

Date

Patient identity	Signature	Identity of legal representative(s)	Signature
Surname Forname Date of birth		Surname, forname, date of birth Surname, forname, date of birth	

CONSULTATION CERTIFICATE

I certify that I have informed the patient or their legal representative Mr/Ms _____ about the characteristics of the investigated disease, the means for diagnosing it, the possibilities of prevention and treatment, the storage of samples and the possibility of contracting out testing, and that I have collected the consent of the patient or their guardian on the conditions provided by the requirements above.

Date

Signature of prescriber

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