Consent for Chromosomal Testing

THE PURPOSE OF CHROMOSOMAL TESTING

Chromosomes are the structures inside the cells of our body containing information that helps direct the growth, development, and physical health of our body. Chromosome testing is performed to determine whether there is any extra, missing or rearranged information within the chromosomes, as this might affect a person's growth, development or health.

OUR PROMISE TO YOU:

1. No test(s) will be performed and reported on your sample other than the one(s) authorized by your doctor. Any unused portion of your original sample will be destroyed within 2 months of completion of testing by the laboratory.
2. CombiMatrix will disclose the test results only to the doctor(s) named below, or to his/her agent, unless you authorize it or it is required by law.

YOUR ACKNOWLEDGEMENT:

1. I know that the decision to consent to or refuse any procedure or test is entirely mine, and will not affect my care, either positively or negatively.
2. The reason for having a chromosomal test performed on me or my child/fetus is:

   _____
3. I am aware that genetic counseling is recommended both before and after testing.
4. I have had the opportunity to discuss the purpose and any possible risks of this testing with my doctor, or with my doctor's agent. I have all the information that I need, and my questions have been answered.

My signature below indicates that I have read (or had read to me) the above information, and that I understand it. I have also been counseled about the types of disorders being tested for, and the specific tests that I am having, including their benefits and limitations.

YES: I request that Dr. _____ has CombiMatrix perform chromosomal testing on me or my child/fetus. I understand and accept the consequences of this decision.

_____ _____ _____

Patient (Parent/Guardian) Signature | Date | Consent obtained by

Please also disclose results to: _____

NO: I decline to have the chromosomal testing that has been offered to me. I understand and accept the consequences of this decision.

_____ _____ _____

Patient (Parent/Guardian) Signature | Date | Consent obtained by

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