



**CONSENT FOR GENETIC TESTING - GERMLINE**

1. In order to help identify the cause of current medical issues or likelihood of such disorders in the future, I/my child/my fetus (*circle one*) will be tested for genetic indicators that may be linked to the following genetic disease or condition (*insert general description of disease/condition*):

2. The tests have been explained to me. I have discussed with my health care provider the risks, benefits, and limitations of genetic testing. I have discussed with my provider the reliability and implications of positive, negative or uncertain results. I have discussed with my provider the extent to which a positive test result may predict disease, that negative results may not eliminate the chance of a genetic cause, and that uncertain results may be found.
3. Updates: Knowledge of genetic testing increases over time and new information may become available that affects the interpretation of my results. I acknowledge that I am aware of this possibility, my provider may recontact me over time, and I should provide updated contact information. I was also advised to ask for updates regarding my genetic testing results over time.
4. Unexpected results: While testing for specific conditions, unexpected genetic results may be reported that are associated with conditions that may have high clinical significance. I have been informed that I may be provided recommendations for medical care to prevent or decrease associated disease severity if unexpected results are identified.
5. Implications for my family:
  - a. Genetic test results may have meaning for my blood relatives. My health care providers can discuss with me whether and how I might want to share my test results with my family.
  - b. Depending on the situation, the interpretation of genetic test results may depend on the genetic test results of a family member. For this reason, my results (not my actual test report) may be referenced in the records of family members, and the results of family members may be referenced in my records.
  - c. Genetic testing in family members sometimes reveals that true biological relationships are not consistent with reported relatedness. For example, misattributed parentage may be detected, which means that the stated parent of an individual is not the biological parent.
6. Sample use: My de-identified sample may in some cases be used for internal laboratory use or test optimization.
7. GINA: Although the Genetic Information Non-Discrimination Act protects against medical insurance and employment discrimination in most cases, it does not prevent possible life insurance, long-term disability or long-term care insurance discrimination. More information can be found at [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/gina](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/gina).
8. Genetic counseling, more testing, or additional physician consults may be necessary after testing in order to complete the testing process. Genetic counseling is important and I have been provided with written information identifying genetic counselors or medical geneticists from whom I might obtain genetic counseling.
9. The test results will be released by the testing laboratory into my medical record and will be available to my health care providers at Boston Medical Center. The provider who ordered the test will share the results with me. The test results will be a part of my medical record at Boston Medical Center.
10. Boston Medical Center will not release the genetic testing report to anyone else without my express, written consent, except as specifically stated in this consent or required by law.

I have read and understand the above document and have had any questions explained to my satisfaction. I acknowledge that I am the patient or I am the patient's legally authorized representative or surrogate and by signing below indicate that I herein voluntarily consent to the above procedure.

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Patient

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Parent/Guardian/Surrogate (if applicable)

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Provider/Physician/Witness (as applicable)

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**GENETIC COUNSELING SERVICES AT BOSTON MEDICAL CENTER:**

For the most up-to-date information about genetic counseling at Boston Medical Center, please visit:  
<http://www.bmc.org/diagnostic-genetics/services.htm>

\*Please note that genetic counseling may require a referral from your health care provider.\*

To schedule appointments, please call:

**OB/GYN Antenatal Services (Prenatal)** 617.414.2000  
**Cancer Center/Oncology** 617.414.1550  
**Clinical Genetics (Pediatrics/Adult)** 617.414.4841



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