impact genetics

Form 1a: *Informed Consent to Perform MLH1/MSH2/MSH6/PMS2/EPCAM Somatic Tumor MMR Sequencing and Deletion/Duplication Test*

The purpose of my DNA test/or my child's DNA test is to look for mutation(s) or genetic alterations known to be associated with the following genetic condition or disease: _____.

By signing below, I acknowledge that:

1. My participation or, as applicable, my child's participation in this DNA testing is voluntary. The decision to consent to, or to refuse the above testing is entirely mine.
2. This testing is done on small biological samples.
3. It is possible that the quantity or quality of sample submitted may be inadequate for testing or that a mutation cannot be identified.
4. When tumor testing shows a mutation(s) or alteration in any one or more of the following genes, *MLH1, MSH2, MSH6, PMS2* and *EPCAM*, the normal sample is analyzed for the same mutation(s). If the mutation is present in the normal sample, this patient may be at risk for Lynch Syndrome which is associated with an increased risk for certain cancer(s) compared to the general population. Consulting a doctor or genetic counsellor is recommended to learn the full meaning of the results and to learn if additional testing might be necessary.
5. Impact Genetics will disclose the test results ONLY to the specialist designated on the Requisition Form (***Form 1b***), or to his/her agent, unless otherwise authorized by the patient or required by law, except as described in point 10 below, no information will be printed or released that discloses the patient's identity, or other confidential information.
6. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
7. Impact Genetics will return any unused tumor tissue to my treating physician or the pathology laboratory once testing is completed.
8. There is a chance that the test may reveal unexpected abnormalities that may be of medical value in the patient's care. Impact Genetics will inform the referring specialist designated below.
9. Until the results of this test are reported, the patient and members of the patient's family should still undergo examinations as prescribed by the referring specialist.
10. If necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives may disclose information that identifies the patient or other confidential information (including test results).
11. I have read or have had read to me, the above information and I understand it. I have also read or had explained to me the specific disease or condition tested for, and the specific test(s) I am having, including the test descriptions, principles and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated.

Consent for Future Research:

After all analysis required to reach a genetic diagnosis is complete, Impact Genetics has my consent to use any surplus DNA or RNA in an **anonymous** fashion for research. No tests(s) will be performed and reported on my sample other than the one(s) authorized by my doctor.

☐ YES ☐ NO

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____