Dynacare®

Form 1a: Informed Consent to Perform Genetic Testing for Uveal Melanoma

The purpose of my DNA test is to look for variant(s) known to be associated with prognosis for survival in patients with uveal melanoma. I understand this test requires tumor and buccal (or other normal) samples for use in prognostic testing.

By signing below, I acknowledge that:

1. My 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.
4. I understand that prognostic genetic tests for uveal melanoma are not entirely predictive. Patients with a good prognosis can develop metastatic disease (albeit rarely) and vice versa.
5. Impact Genetics will only collect, use, and disclose your personal health information as permitted/designated on the requisition/order form or required by applicable laws. For example, if necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives, may disclose personal health information (including test results) for such purpose.
6. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
7. 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 on the requisition/order form.
8. 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.
9. 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.

Signature of Patient:_____ Date:_____

Signature of Witness:_____ Date:_____