Patient ☐ male ☐ female ☐ divers
______________________ Last name, first name(s)   ____________ date of birth
____ Street
____ Postal code, City, Country

Universitätsklinikum Carl Gustav Carus

DIE DRESDNER.

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Consent for genetic analysis according to the German Genetic Diagnostics Act (Gendiagnostikgesetz - GenDG)

Please note that samples sent without filled consent form or with illegible form will result in no test being performed.

Reason for referral____

During the consultation we have discussed the following issues and I agreed to the issues indicated below.

I have had the opportunity to discuss the benefits, possible risks and limitations of the requested genetic analysis, the nature of the requested test has been fully explained to me, and all my questions have been answered. I have been informed that the stored sample as well as the result report are regarded as part of a patient's medical record and are therefore kept in medical confidence. These can only be accessed by an authorized health-care professional.

I agreed, that the test results will be shared
with the referring physician:____

and additionally with: ____

According to the Genetic Diagnostics Act (GenDG) entered into force in Germany on February 1st, 2010, a DNA/blood sample must be discarded after the requested genetic test has been completed unless the patient requests to store the sample. A report of the result will be kept for 10 years unless the patient requests to keep it longer. The stored samples as well as result records can help counseling other members of the patient's family now and in the future.

Please specify your decision about the analysis, storage of the sample and the result reports (mark applicable)	Agreed	
	Yes	No
Sample storage for validation and quality assurance purposes after completion of the requested analysis	☐	☐
Sample storage for possible new testing strategies available in the future after completion of the requested analysis	☐	☐
Sharing of my (my child's) information and results for counseling other family members.	☐	☐
Usage of the sample for research on causes and treatment of genetic disorders. I agree to the sample being used in the Institute of Clinical Genetics, Technische Universität Dresden, Germany.	☐	☐
Storage of the test results longer than the legally required period of 10 years.	☐	☐
The sample can be forwarded to another specialized laboratory if this is required to complete the requested test(s).	☐	☐
Other remarks:		

I have been informed that I can withdraw my consent at any time as a whole or in parts.

To be completed by the patient / legal guardian	To be completed by the physician Print name/hospital/department (stamp)
____________ Date ______________ Signature	____________ Date ______________ Signature