Declaration of consent for genetic analysis

ZOTZ | KLIMAS
PARTNER FÜR DIAGNOSTIK & PRÄVENTION
INSTITUTE FÜR MEDIZINISCHE GENETIK
DÜSSELDORF | KÖLN | AACHEN

Patient **Last Name, First Name** _____ **Date of Birth (DD/MM/YY)**: _____ / _____ / _____	**Stamp Hospital / Office** **Date, Name (Physican), Signature**

Question to be clarified

_____

Genetic examination / Name of gene

_____

My attending physician explained to me the meaning and implications of the diagnosis under consideration, in particular with regard to purpose, type and scope. The informative value and consequences of the investigation have been explained also.	☐ yes ☐ no
I agree to the necessary collection of examination material.	☐ yes ☐ no
There was a sufficient amount of time to reflect about the above mentioned investigation and I am entitled to withdraw my consent at any time in written form.	☐ yes ☐ no
I agree to the preservation of any remaining samples for verification of results or additional demands by my physician. I also agree to the storage of my samples for scientific purposes (e.g. method development) unless I withdraw my consent in written form.	☐ yes ☐ no
The request for examination can be forwarded to a specialized medical cooperation laboratory.	☐ yes ☐ no
Die Untersuchungsergebnisse können über die vorgegebene Frist von 10 Jahren hinaus aufbewahrt werden.	☐ yes ☐ no
Clarification of additional results: Genetic analysis can provide information, which are not related to the investigation, but nevertheless of medical importance to me or my relatives. In case of proof, I would like to be informed about additional findings. If no explicit selection is made, we assume from "No, I don't want a recon.". I am aware that I have no claim to completeness or future updating of such additional findings.	☐ yes ☐ no
Transmission of personal data (including health data and genetic test results) from me/my child to other physicians, clinics or other institutions who are involved in the treatment (e.g. surgical center) □ exclusively to: _____	☐ yes ☐ no

_____ _____ _____

Place **Date** **Signature Patient / Guardian**