THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

Pathology & Lab Medicine

New York State Informed Consent for Chromosomal Analysis

What is chromosome analysis? Chromosomes contain genetic material called DNA. Chromosome analysis is used to look for abnormal number or structure of chromosomes. The test can be performed on a blood, tissue, or amniotic fluid. Cells are cultured and harvested then the chromosomes are examined under a microscope.

What is the purpose of this test? Analysis of blood can detect chromosome abnormalities that can cause birth defects, an abnormal appearance, or developmental delay in children. Amniotic fluid can be studied to detect chromosome abnormalities in a fetus. Chromosome analysis can also detect some causes of miscarriages.

What are its limitations? Chromosome analysis is very reliable and time-tested but it can not detect every genetic problem. Your physician or a genetic counselor can provide additional information about the specific value of this test to you. You can choose to speak with a genetic counselor before agreeing to this test.

How will I obtain results from this test? Chromosome analysis is a complex test that can take weeks to complete. A written report is sent to your physician who will inform you of the results and discuss them with you. Your physician may recommend follow-up genetic counseling or additional testing.

What happens to my test results? Test results become part of your medical record and are available to individuals and organizations with legal access to your medical record, including but not limited to the physicians and nurses directly involved in your care, your current and future insurance carriers, and others specifically authorized by you to gain access to your medical records.

What happens to my sample after testing? The only testing that will be done on your sample is chromosome analysis unless your physician requests additional testing. Your blood sample will be discarded within 60 days of completion of the test. The DNA will be retained for at least 6 months.

If you consent, we would like your permission to use your sample as a negative or positive control sample in future laboratory testing. If you do agree, we will remove your name and all identifiers prior to re-testing and the sample and results obtained will remain anonymous (check box below).

☐ I will allow my sample to be used anonymously as a control or for other routine laboratory use.

☐ I do NOT want my sample used for anything except the ordered tests. I want my sample discarded within 60 days.

My signature below indicates that I have received information about this test and that I have read and understood this document. I have been given a full opportunity to ask questions that I may have about the testing procedure and related issues. I agree to undergo this testing.

Name of Person Obtaining Consent: _____ Title: _____

Signature: _____ Date/Time: _____

I have read and fully understood the above, and give my consent for this testing.

Patient name: _____

Patient Signature: _____ Date/Time: _____

If consent is given by parent or legally authorized representative:

Name: _____ Relationship: _____

Signature: _____ Date/Time: _____