ALBANY MEDICAL CENTER
SPECIAL CHEMISTRY LABORATORY
Phone: 518-262-3519
FAX: 518-262-8257

ATTESTATION FOR GENETIC TESTING

Patient Name: _____

MR #:_____ Acc#_____

Date of Birth: _____

Date of sample collection: _____

Test Ordered: **CYSTIC FIBROSIS TESTING**

For AMC Lab Use Only

Physician:_____

Faxed:(date)_____#:_____

Date Faxed to SO Lab:_____

New York State requires laboratories to have documentation that the appropriate health care provider has obtained informed consent from patients before the laboratory conducts pre-symptomatic and carrier genetic testing. Laboratories may not release the results of such testing without the required documentation.

Informed consent includes the following:

- Patient understanding the purpose of the test
- How the test is performed
- The reliability of the test
- Alternatives to testing
- Implications of test results
- Options on how to instruct the laboratory to store, use or dispose of the sample when testing is complete.

Please check the statement applicable to this patient and sign below so that the testing laboratory may release the results for this patient.

[ ] I have ordered the above mentioned test(s) for the purpose of diagnosing an existing disease and therefore informed consent as described above is not required.

[ ] I have provided appropriate informed consent for the above mentioned test(s) and documentation of this consent is maintained in the patient record.

Patient Information

DNA Indications for Testing

- ☐ No family history (screening)
- ☐ Family Hx:_____
  relative:_____
- ☐ Abnormal fetal U/S*_____
- ☐ Congenital absence of vas deferens
- ☐ Infertility

Ethnicity

- ☐ Caucasian
- ☐ Asian
- ☐ Hispanic
- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Other:_____

Any other indications not listed above, provide ICD-9 code:_____

*Provide additional information:_____

Physician/Genetic Counselor signature:_____ **Date:**_____

Printed Name:_____

Include this consent with the specimen at the time of collection.