



***Prothrombin G20210A Mutation
Genetic Testing Consent Form***

**Albany
Medical
Center**

PATIENT IDENTIFICATION PLATE

I understand that some hypercoagulation diseases are the result of a mutation in the prothrombin gene. The estimated risk of thrombosis is 2.8 times as high among individuals with this mutation in one gene (heterozygous carriers) as among persons without the mutation. The risks among individuals with the mutation in both genes (homozygotes) is currently unknown. I also understand that if I do not possess this mutation I may still be at risk for thrombosis from other genetic or non-genetic causes.

I have been informed that Albany Medical Center performs Prothrombin Gene Mutation testing by Molecular (DNA based) methods and that this analysis has been shown to be more than 99% accurate. I agree to the collection of one 3 ml (approximately 2 teaspoons) of blood for the purpose of testing. I understand that testing is performed three times a week, and that the results will be available to my physician in 4 to 10 days. I understand that if I so request, genetic counseling will be available to answer any questions I may have about the results of my test.

In agreement with the New York State Genetic Testing Confidentiality Law, I attest that I have been informed of the nature and limitation of this genetic test and I give my permission to my physician to send my blood specimen to the Molecular Diagnostics Laboratory at Albany Medical Center for testing. I authorize the laboratory to report the results to my physician or diagnostic center.

Signature of Physician

Date

Signature of Patient

Date