ALBANY MED Health System

ALBANY MEDICAL CENTER

Patient Identification Plate

Consent for Factor II (Prothrombin) and Factor V (Leiden) Gene Mutation Testing

I understand that some hypercoagulation disorders are the result of mutations in the Factor II (Prothrombin) and Factor V (Leiden) genes. The estimated risk of thrombosis is 2.8 times higher among individuals with one copy of the Factor II gene mutation (heterozygous carriers) compared to those without the mutation. The risk among individuals with mutations in both genes (homozygotes) is currently unknown. The estimated risk of thrombosis is 7 times higher among individuals with one copy of the Factor V gene mutation (heterozygous carriers) compared to those without the mutation, and individuals with the mutation in both genes (homozygotes) have an estimated 80 times increased risk. I understand that if I do not possess either mutation, I may still be at risk for thrombosis due to other genetic or non-genetic causes.

I have been informed that Albany Medical Center performs both Prothrombin and Factor V gene mutation testing using molecular (DNA-based) methods, and that these analyses have been shown to be more than 99% accurate. I agree to the collection of one 3 mL blood sample for the purpose of testing. I understand that I have the right to seek genetic counseling before testing. I understand that upon request, genetic counseling will be available to answer any questions I may have regarding the results of my testing.

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. No unauthorized tests will be performed on this sample, and the sample will be destroyed within 60 days.

Patient or Authorized Representative Name: _____

Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____