



Please send a copy of this document with official request for investigation and probe material back to:

### Molecular Diagnostics Laboratory

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## Informed Consent for Genetic Testing

I have been informed by Dr.: .....

about the purpose, scope, significance, and implications of the planned genetic test, as well as about my legal rights. I have been granted an adequate period for reflection. My information is subject to medical confidentiality.

**I agree to the collection of sample material (e.g. blood sample) and request the following genetic test(s):**

.....  
(e.g. sequencing of the gene(s) HFE, MEFV, or others)

For the diagnosis of the following condition(s):

.....  
(e.g. Hereditary haemochromatosis, Familial Mediterranean fever, or others)

Applicable to: ☐ myself ☐ my child ☐ the person under my care: .....

The test result shall be communicated to the above-mentioned physician, if applicable to co-treating physicians of the University Medical Center Ulm, and for information to the following physician:

Dr.: ..... Department/Practice: .....

My test results and records will be stored at the University Medical Center Ulm for the legally prescribed period of 10 years. I have been informed that I may revoke this consent at any time, in writing or verbally, without any disadvantage to myself. I may request the complete or partial destruction of the test results at any time. Any further genetic testing requires a new test order and my renewed consent.

**I would like to be informed about the test results:** ☐ Yes ☐ No

### Unused sample material

- ☐ May be used in pseudonymized form for internal *laboratory quality assurance* (control sample) and for *scientific purposes*.  
☐ Shall be stored for diagnostic purposes only for 30 years.  
☐ Shall be destroyed after completion of the above-mentioned tests.

.....  
Place, Date

.....  
Patient / Legal Representative (Name, First Name, Date of Birth)

By signing, I also confirm that I have been provided with a copy of this consent form.

.....  
Signature of Patient / Legal Representative

(if applicable, patient label)

.....  
Signature of Responsible Physician

The German Act on Genetic Testing in Humans (Gendiagnostikgesetz – GenDG) stipulates that genetic analyses may only be performed after a written consent form has been provided by the person to be tested or their legal representative. Furthermore, the responsible (i.e., requesting) physician must provide detailed information about the significance of the diagnostics. In the case of an abnormal finding, professionally qualified genetic counselling must be offered. Genetic counselling is required before and after prenatal or predictive (forecasting) diagnostics.

**Distribution:** **Original:** Medical record of the responsible physician. **Copy** to the contracted laboratory. **Copy** to patient/legal representative.