STONY BROOK
STATE UNIVERSITY OF NEW YORK

UNIVERSITY HOSPITAL AND MEDICAL CENTER, LEVEL 5, SUITE 2

Division of Genetics
Genetic Counseling

MRN #: _____

CYTOGENETICS INFORMED CONSENT

Patient Name: _____

By signing below, I authorize Patricia Galvin-Parton, MD and/or David H. Tegay, DO and their genetic counselor associate (s) to obtain a sample from _____ for:

□ Routine/high resolution chromosome analysis
□ Subtelomeric FISH analysis
A description of that has been provided to me.

□ FISH for _____
□ Other: _____
Indication: _____

1. New York State civil rights law (Article 7 Section 79-1) requires that no person perform a genetic test on a sample from you without prior written consent from you (the patient) or your representative. This test is a genetic test when it is used to identify an inherited chromosome abnormality.
2. This test determines the chromosome number and structure in the cells that are submitted for chromosome analysis. This test routinely includes a conventional chromosome analysis, and in some cases, molecular cytogenetic techniques may be performed to identify structural chromosome rearrangements that cannot be identified by conventional chromosome analysis.
3. This may reveal abnormalities of chromosome number and structure. An abnormal chromosome number is usually clinically significant, and may be associated with clinical abnormalities. Abnormalities of chromosome structure include but are not limited to duplications, deletions, inversions, transpositions, and translocations of chromosome regions. Structural abnormalities may have reproductive consequences, and in some cases, structural abnormalities may be associated with clinical abnormalities as well. Consulting with a geneticist or a genetic counselor prior to signing this informed consent and following receipt of results is recommended to learn what the results may mean for you and your family.
4. This test may not detect chromosome abnormalities that are present in a small percentage of cells, and the test may not detect small structural chromosome abnormalities that are beyond the resolution of current techniques. For all tests, there is a possibility the cells will not successfully grow, and the chromosome analysis will not be completed. For prenatal testing, a normal result will not guarantee the birth of a normal child. Approximately 3-4% of all pregnancies have birth defects that cannot be detected by chromosomal analysis.
5. No tests, other that those you authorize as described above, will be performed on this sample. The sample will be destroyed at the end of the testing process or not more than sixty days after the sample was taken, unless you consent to a longer period of retention or the sample is retained for laboratory quality control and / or research purposes. If the sample is retained, all patient identification will be removed from the sample; it will become anonymous. *If you do not want this sample retained for laboratory quality control and/or research purposes, please initial here.* _____ .
6. Results of this testing will become part of your medical record. All results will be communicated to you, and copies will be forwarded to your referring physician. Your results may otherwise be released only to the person(s) or institution(s) you indicate here: _____ .

My signature below constitutes my acknowledgment that (1) the purpose(s) and limitations of this test have been adequately explained to me by a physician and/or genetic counselor and (2) I give my authorization and consent to this test.

_____ _____
Signature Date
Relationship to patient: □ *Self* □ *Parent*

_____ _____
Witness Date