NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

Consent for Predictive Genetic Testing

Patient LAST name:	FIRST name:	MIDDLE initial:
Date of birth:	Hospital/Medical record patient ID number:	
Test ordered by:	Condition(s) for which genetic testing is requested:	
Laboratory name:	Name of test:	
Laboratory City / State:		

- I have reviewed this consent form and the "Nebraska Patient Education about Genetic Testing" brochure with my health care provider.
- I have been told what kind of test this is, and what it is supposed to show.
- I have been told about the limits of this test, and what it cannot tell me.
- I have discussed the benefits and risks of this test with my health care provider.
- I have been told who may have access to the test sample. I know that any leftover sample may be kept by the lab. I know that it may be used for more testing or for quality control.
- I have been told how I will receive the results.
- I understand the test results could be normal, abnormal or uncertain.
- I have been told who may be able to see the test results. I know the results will become part of my (or my child's/ward's) confidential medical record.
- I know that doctors will understand more about the meaning of test results in the future. Because of that, I should check with my health care provider for updates from time to time.

I am asking this laboratory to perform this test. **If the test might give me information about more than one condition, here is what I want to know beyond the reason I am having this test:**

Yes	No	
☐	☐	I want to learn about known genetic changes that **put me or my child at risk right away for health problems that can be treated.**
☐	☐	I want to learn about known genetic changes that **might change the way my doctor treats me** or my child. This includes changes that affect the way medicines work in my body, and changes that give me a higher risk for diseases now or in the future.
☐	☐	I want to learn about known genetic changes that give me or my child higher risk for diseases in the future, **even if there is nothing I can do now** to reduce the risk of the disease.
☐	☐	I want to learn about known genetic changes (carrier status) that are not likely to be harmful to me but could be harmful to my child or grandchild if passed on in the future.
☐	☐	I want to learn about results that could mean my family tree is different than I expected, such as adoption, mis-identified paternity, or parents who are close blood relatives.

I agree to have a sample taken for genetic testing on the patient named above for the condition(s) listed above:

_____ Select one: ☐ Self ☐ Parent ☐ Legally Authorized Representative
Signature

Print name of health care provider explaining the information above: _____

Signature of person explaining the information above: _____ Date: _____

If I have questions, I should call: _____ at _____

ORIGINAL: Place in patient's medical record. An electronically scanned copy retained in the patient's medical record is acceptable.

COPY: The patient or patient's representative is to receive a copy of this completed form and a copy of the Nebraska Patient Education About Genetic Testing brochure.