Cerba

GENETIC INFORMED CONSENT FORM

☐ POSTNATAL DIAGNOSIS

Please complete and sign the consultation certificate and consent form below.
The elements to be completed in this document must be provided. Failure to do so will prevent the prescribed genetic test(s) from being carried out.

Consultation certificate from the prescribing physician or the genetic counselor

(insert for prescribers)

I, the undersigned, Dr/Pr [*First name, Last name*]……,
or Mrs/Mr [*First name, Last name*] ……, genetic counsellor*

Certify that I have received for consultation today:
Mrs [*First name, Last name*] ……, Born on [*Date of birth*] ……

Certifiy that I have provided him/her (or the person with parental authority or his/her guardian) with all the information mentioned in articles R. 1131-4 and R. 1131-20-1 et seq. of the French Public Health Code, as well as under the terms of the texts adopted for their application:

1. The characteristics of the disease under investigation, the means of detecting it, the degree of reliability of the tests and the possibilities of preventive measures, including genetic counselling, and care
2. The modes of genetic transmission of the disease under investigation, when known, and their potential consequences for other family members
3. That the examination may incidentally reveal genetic characteristics unrelated to its initial indication but knowledge of which would enable the person or members of his or her family to benefit from preventive measures, including genetic counselling, or care
4. That, if the diagnosis of this anomaly is confirmed, she is obliged to inform, by any means possible, the members of her family who may be concerned.

** In accordance with articles R. 1132-5 et seq. of the French Public Health Code.*

Information and Consent of a Person's Genetic tests

(patient insert)

I, the undersigned, Mrs/Mr [*First name, Last name*] ……**, certify that I have received from the above-mentioned doctor, during today's medical consultation:**

- Information concerning the genetic characteristics examination proposed to me, **to which I consent**, and which will be carried out based on the biological sample(s) collected [*check the appropriate box*]:
  - ☐ About myself
  - ☐ On my minor child or the adult under my guardianship

- Information about the examination of genetic characteristics to which I consent, and which will be carried out in order to [*check the appropriate box*]:
  - ☐ To establish, confirm or rule out the diagnosis of a genetic disease in a person;
  - ☐ To investigate the characteristics of one or more genes likely to be at the origin of the development of a disease in an person or the members of her family potentially concerned;
  - ☐ To adapt the medical care of an individual based on their genetic characteristics.

I have been informed:

- All the information contained in the medical consultation certificate
- Of my right to have this request for examination(s) stopped at any time, to have the results not communicated to me, or to have the retained samples destroyed.
- That the interpretation of these results depends, in certain situations, on the definition of biological parentage, which can be analyzed on the basis of these samples.
- The conditions for informing relatives and my responsibility concerning my duty to inform my family and, where applicable, to inform the procreation center in the case of gamete donation, if a serious genetic anomaly is detected, requiring preventive measures including genetic counselling or care.
- That the result is confidential. It will be returned to me and explained in consultation by the prescriber

I consent to the sample collection and the conduct of the examination in the context of [*describe clinical context*] ……
……

The technique used may reveal genetic information unrelated to the pathology concerned, but which could have an impact on my/our health or that of related persons, on my/our care and/or treatment. ***I wish to be informed of these results.***	☐ YES ☐ NO
I accept, if my results appear to be medically essential for my relatives, that they may be communicated and used in an anonymized way, in their interest, even after my death.	☐ YES ☐ NO

This (or these) examination(s) will be carried out in a medical biology laboratory authorized by the Agence Régionale de Santé to perform them. The original of this document is kept in my medical file. A copy of this document is given to me and to the practitioner who will carry out the examinations. The medical biology laboratory in which the practitioner who carried out the examinations works keeps this document under the same conditions as the examination report. I have had the opportunity to ask any questions I may have had to the geneticist or genetic counsellor who prescribed this examination, and I have received full and adequate answers.

Done in …… **on** ……

PATIENT ID (Signature)	LEGAL REPRESENTATIVE ID (Signature)	PRESCRIBER (Signature)
Last name, First name, Date of birth:	Signature of 2 parents required for TRIO analysis (index case + 2 parents) *Last name, First name, Date of birth:* *Last name, First name, Date of birth:* If the patient is minor or an adult under guardianship, relationship to the patient:	*Last name, First name*