☐ Fairview Lakes Medical Center (and Clinics)
☐ Fairview Northland Medical Center (and Clinics)
☐ Fairview Range Medical Center (and Clinics)
☐ Fairview Ridges Hospital (and Clinics)
☐ Fairview Southdale Hospital (and Clinics)
☐ University of Minnesota Health Maple Grove Clinics
☐ University of Minnesota Medical Center (and Clinics)
☐ University of Minnesota Masonic Children's Hospital (and Clinics)

Consent for Collection of Genetic Information

To provide the best medical care, your care team needs to collect genetic information from you or your child. Your doctor or care provider has ordered one or more genetic tests (called DNA or chromosome tests). Genetic tests can be done on blood, hair, tissue or other samples taken from the body. We require your consent to do genetic tests. Your care team may also get genetic information from your medical and family history.

Summary of the patient's discussion with health care provider

A doctor or other care provider has explained, in terms that I could understand:

- The diagnosis or condition that requires genetic testing, listed below:

  _____

- The type of genetic testing needed
- How my care team will use the results in care of me or my child
- The possible benefits and risks of the testing and of collecting genetic information
- Other options, if no genetic testing is done
- Other special concerns: _____.

Patient consent for the collection of genetic information

I allow the collection and testing of genetic information as outlined here:

- The information will be collected and used for genetic testing for the condition listed above.
- The lab that tests the blood or tissue will decide how long to store the genetic material.
- All results and reports will be sent to the doctor or care provider who referred me for these tests.

Note to patient: You will receive a copy of this form from your pre-op nurse. If you have questions, please speak with the provider who ordered your tests. Or to make an appointment with a genetic counselor, call 612-365-6777 (choose option 1).

_____

Patient, Parent or Legal Representative Signature and Printed Name

_____ _____

Relationship to Patient *Date*

- Continued on next page

To be completed by person(s) witnessing or verifying the patient's or patient's authorized decision-maker's signature. Initial one of the three options below and sign the signature line.

- I have witnessed the signature of the patient or patient's authorized decision-maker. _____*(initials)*
  Or:

- I have heard the telephone consent of the patient's authorized decision-maker. _____*(initials)*
  _____*(initials)*
  Or:

- I have verified that the signature completed before the patient's arrival for the procedure is that of the patient or patient's authorized decision-maker. _____*(initials)*

Signature	*Date*	*Time*
Signature of 2nd person witnessing Authorized Decision Maker's telephone consent	*Date*	*Time*
Interpreter name (if used)	*Language/Organization*	*Date* *Time*

To be completed by the provider/practitioner: I have explained the collection and testing of genetic information to the patient, parent or legal representative, and have explained how this information will be used.

Signature	*Printed Name*	*Date*	*Time*
Interpreter Name (if used)	*Language/Organization*	*Date*	*Time*