

For Healthcare Providers:

In the state of Massachusetts, written informed consent is required for all non-diagnostic genetic testing. Non-diagnostic genetic testing includes any genetic test EXCEPT those that are done to diagnose or find an existing disease, illness, impairment or disorder.

Obtaining and documenting informed consent for genetic testing is the responsibility of the ordering provider. Healthcare providers may use their own consent form or the form below, which conforms to Massachusetts state law (Massachusetts General Laws, Chapter 111, Section 70G).

For Patients:

I understand that:

1. The purpose of this test is to find out if I or my child may have a pathogenic (disease causing) variant in the gene(s) being tested. Pathogenic variants in these gene(s) have been linked to _____ (list disease(s)/condition(s)). My healthcare provider has given me information about the test(s) and the condition(s) it may find. This information is also available on the LMM’s website at <http://pcpgm.partners.org/LMM>.
2. I know that if I want to, I can have genetic counseling. My healthcare provider gave me written information about genetic counseling services, if I want to learn more about this condition.
3. I have talked with my health care provider about what the results of this test might mean for me or my child. I understand that when I or my child is the first person in my family to be tested, or when a pathogenic (disease causing) variant has not yet been found in my family, a negative genetic test result means that
 - I or my child may still have this condition.
 - I or my child may be more likely to get this condition.
 - I or my child may pass on this condition.
 - The gene(s) tests are less likely to be the cause of my or my child’s condition(s).
4. I have discussed with my healthcare provider that this genetic test only tests for the condition(s) listed and not for anything else. Therefore, a negative result does not mean that I or my child will not have other health problems.
5. In some families, genetic testing might discover information about family relationships that you did not know about. This includes things like adoption or that someone has a different father than what was thought.
6. The healthcare provider that ordered this test will receive the results of my genetic testing and they will tell me the results.
7. I understand that my test results and any updates to those results may become part of my permanent medical record (electronically or otherwise). These results may be sent (electronically or otherwise) to the healthcare institution and team that ordered.
8. I understand the policies of the Laboratory for Molecular Medicine and agree to give a sample for genetic testing to this laboratory.

I have carefully read and understand the above statements. I have had all my questions answered and I agree to provide a sample for testing.

Name of patient (please print)

(If applicable) Name of patient’s legal representative (please print)

Signature (Patient or patient’s legal representative) Date

Signature (Ordering provider) Date