

Patient's number: .....

### Consent of the examined person (legal representative) with genetic laboratory testing

.....  
Surname, first name of the examined person

...../.....  
Insured person no.: / Date of birth

**Purpose of genetic laboratory testing:**

- Verification/confirmation of the diagnosis     Detection of predisposition to disease  
 Determination of disease transmissibility     Diagnosis of fetal disease  
 Other.....

Anticipated benefit of this laboratory testing:.....

**Physician's declaration:**

I declare that I clearly and comprehensibly explained to the examined person (his/her legal representative) the purpose, nature, anticipated benefit, consequences and possible risks of the above stated genetic laboratory testing. I also informed the examined person about possible results and consequences in case the examination would not be possible to perform with the intended purpose (it would fail) or it would not have the predicative value to fulfill the pursued effect. I have informed the examined person (legal representative) about the possible risks and consequences in case of rejection of this testing. The laboratory testing results will be confidential and shall not, without the consent of the examined person/legal representative, be disclosed to a third party if applicable legal regulations do not specify otherwise.

Physician's name .....Stamp and signature of the physician.....

Date.....

**Declaration of the examined person:**

I confirm I have been provided with genetic counseling concerning the genetic laboratory testing for the purpose stated above. All information have been provided and explained to me clearly and comprehensibly. I have had the opportunity to properly, untroubled and with sufficient time consider everything and I have had the opportunity to ask the doctor about everything I have judged as essential for me and useful to know and discuss with him/her everything what I did not understand. I have been provided with a clear and comprehensible answer to my questions. For the purpose stated above I agree that a sample from my body shall be taken and the following tests shall be performed:

- Cytogenetic examination*     Karyotype     Other.....  
*Molecular-genetic examination*     Testing for the disease .....     Other.....  
*Other examinations*     Other.....

from the sample:

- Peripheral blood     Amniotic fluid     CVS (villi)     Saliva     Umbilical blood  
 Placenta     Tissue; skin, muscle     Ejaculate     Blastomere     Other.....

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**I also wish the following:**

- I wish /  I do not wish to be informed about the results of the genetic laboratory testing

- I wish that the following persons shall be informed of the results of the testing:

Name and surname:.....

Address of the authorized person:.....

- I agree /  I do not agree that I am listed in the patients' registry

- I agree /  I do not agree that my DNA shall be retained in the laboratory for the purpose of another possible analysis depending on the advances in research which will be performed to my advantage and the advantage of my family. If I do not agree the sample will be destroyed with a risk that the result of the examination will not be possible to verify again in the future and a new collection of the material for the genetic testing will be needed.

- I agree /  I do not agree with anonymous use of DNA for medical research and with publication of the obtained results in the scientific publications

Based on this information I agree that the relevant sample shall be taken from my body and the above described genetic testing shall be performed.

I am aware that I can withdraw my consent any time.

I declare I understood all data, information and consents I had been provided and explained.

In ..... date .....

**Signature of the examined person**.....

Name of legal representative:..... Personal ID:.....

Relation to the examined person:.....

Signature of the legal representative.....