Center of Medical Genetics
Sir Ganga Ram Hospital
Rajinder Nagar, New Delhi – 110060
Telephone No : 25861767, 42251992 – 93,
Fax : 91 11 25862206
Laboratories: **Molecular: 42252115-16, Cytogenetic: 42252110-11,**
Biochemical: 41152112, HLA: 42251999

REQUEST FORM FOR GENETIC STUDIES

1. Name of Patient: …… 2. Date of birth ……

3. Ethnic Group: ……4. Sex ☐ Male ☐ Female

5. Test Requested: ☐ Molecular ☐ Cytogenetic ☐ Biochemical ☐ HLA

……..

6. Sample being sent: ……

7. Clinical Indication: .....

8. Brief Clinical details: ……...

……..

……..

9. Family history: Consanguineous: ☐ Yes ☐ No (If yes, Specify)

……

10. Payment details: ……...

……

11. Signature with Name/ Address/ Fax/ Email/ cell phone of referring authority

12. Address for posting report: Email/ Phone/ Mobile, if different from above

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INFORMED CONSENT FOR GENETIC STUDIES:

Name of Patient:

I, son/ daughter /guardian of ……..Resident of ……

……..……..

Hereby agree to participate in Genetic Studies for ……...

I understand that:

- The test being performed is specific for the disease being tested and in no way guarantees absence of other disorders.
- In some cases specific mutations are tested. This would not exclude presence of other mutations in the gene in question.
- At times diagnosis / carrier screening / prenatal diagnosis is carried out by linkage studies. This does not test for specific disease causing mutation(s), but establishes the diagnosis by tracking the mutant chromosome. Recombination introduces a small chance of error in this technique (3-5 %).
- I understand that in most cases, a negative test result does not necessarily rule out a genetic condition.
- Results of genetic testing are to be interpreted along with the results of other types of testing, clinical evaluation and family history.
- Lack of all needed family members may compromise the quality or decrease the accuracy of the result.
- No tests other than those authorized will be performed. However, any remaining sample may be used for quality control purposes or for research, but the analysis should be carried out anonymously.
- Despite the highly accurate nature of Genetic testing and laboratory quality control measures, errors (false positives and false negatives) may occur at a frequency estimated to be about 1%.
- The results will be reported to me only, or to my physician or to the person I nominate.
- My signature below acknowledges my voluntary participation in this test, appreciating the above limitations.

Date ……..…….

Witness: Name & Address: Name and address

Signature: ……... Signature: ……...

ALTERNATE INFORMED CONSENT: Physicians / Counselor's statement:
I have explained the benefits and drawbacks of Genetic studies to this individual. I have addressed the limitations outlined above, answered this person's questions and I have obtained consent to order the above test.

Date: …… Signature:

Name/ Address/ Fax/ Email of Physician / Counselor