Genome1st LLC Medical Genetics Practice
Provider: Apostolos "Paul" Psychogios, MD, DABMGG, FACMG
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CLIENT INFORMED CONSENT FORM FOR GENETIC TESTING

First Name: _____
Last Name: _____
DOB (MM/DD/YYYY): _____

I understand that Dr. Apostolos Psychogios has ordered the following genetic testing for myself or my child:

_____
Diagnosis:

_____
ICD10 code (s):

_____

I am interested in obtaining a genetic test by submitting a biological sample of my own or child (saliva, buccal swab, blood, or other tissue). The purpose of this voluntary molecular genetic test is to find if I or my child is carrying a gene mutation predisposing to or causing disease or elevated health risks. The biological sample sent is needed for isolation and purification of DNA and molecular genetic testing by Next Generation Sequence analysis (NGS) or other clinically validated method.

I was informed in detail and understand that:

1. Genetic testing results will be reported only by Dr. Psychogios to me.
2. Genetic testing performed is associated or specific to the condition or diagnosis told above. The results will be evaluated in the context of my personal and family medical history, significant physical examination findings, laboratory and imaging, and the clinical impression of Dr. Psychogios and my provider (s).
3. Possible molecular result outcomes include positive (pathogenic or likely pathogenic), negative, and variants of uncertain significance (VUS) per current American College of Medical Genetics (ACMG) guidelines.
4. Unexpected or unclear results may be revealed from this test in rare instances including unexpected biological relationships, such as a different biological parent, sibling, or other.
5. Currently used testing technology is sometimes unable to detect a disease-causing mutation for various reasons including I) other unknown genes associated with reported above disease susceptibility at this time, II) sample contamination or mix-up, III) unavailable samples from other informative relatives, IV) inaccurate reporting of family relationships, or other history, V) other technical problems, but not limited to these stated herein.

Client consent statement

By signing below, I, the client having the above test performed, acknowledge that:
I have read or showed to me all the above statements, understand this information completely, had the opportunity to ask questions, and agree. I understand the procedure, the risks, benefits, limitations, and the alternatives associated with this test.

I consent to the following types of genetic results:
1. Primary results associated with my condition: Yes No (circle one)
2. ACMG secondary results: Yes No (circle one)
3. Carrier of autosomal recessive disorders: Yes No (circle one)
4. Other pathogenic mutations associated with dominant disorders: Yes No (circle one)
5. Pharmacogenomic results (as applicable): Yes No (circle one)
6. Triplet-repeat disorders (as applicable): Yes No (circle one)
7. Pediatric disorders: Yes No (circle one)
8. Adult-onset disorders: Yes No (circle one)

I consent Dr. Apostolos Psychogios and I receive the raw genomic data files for future reanalysis:
1. FASTQ: Yes No (circle one)
2. BAM: Yes No (circle one)
3. VCF: Yes No (circle one)

I can request a copy of this consent form at any time.

Client
Name: _____
Date: _____