Requisition form

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: Surname ……First Name……..

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 for test: .....

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*

(Please complete the consent form and send along with)

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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 would 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 and agreement to the terms laid down.

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 of genetic tests, answered this person's questions and I have obtained consent to order the above test.

Date: …… Signature:

Name/ Address/ Fax/ Email of Physician / Counselor

PRENATAL TESTING

Prenatal Testing-

- Two consent forms have to be filled for each case for prenatal testing-
  1. Form G (as per the PNDT act),
  2. Consent form for Hospital (SGRH)

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Tel No: 42251992-3 (Direct)-011- 25861767 Helpline-09654290523
Fax :91-(0)11- 25862206. Email: dr_icverma@yahoo.com

CONSENT FORM FOR PRENATAL DIAGNOSTIC TESTS (SGRH)

I. . . . . wife of. . ……..

resident of. . . . . ., ...

request and authorise the **Scientific Staff of Genetic Laboratory, Center of Medical Genetics, Sir Ganga Ram Hospital,** New Delhi to carry out **Prenatal Diagnostic Tests** indicated below

1. Chromosomal studies 2. Molecular studies 3. Biochemical studies

on ☐ Chorionic villus samples. ☐ Amniotic fluid sample.

☐ Fetal blood sample ☐ Other sample(s)

It has been explained to me in simple language and I understand that.

1. There is a very small possibility that growing the fetal cells or tissue may not be successful or Molecular, Chromosomal/Biochemical analysis may not be successful so no / (equivocal) results may be obtained.
2. Repeat amniocentesis / CVS sampling may be required.
3. The test results cannot be guaranteed to be 100% accurate, as 1-2 % chance of error exists in biological tests.
4. Every effort is made to obtain the results as soon as possible. Occasionally no results are available until 3-4 weeks after taking the sample.
5. The results provided of normal chromosomes or normal molecular or normal biochemical status of the fetus does not eliminate the possibility that the child may have birth defects and / or mental retardation because of other cause(s).
6. Any fetal fluid or tissue remaining after the test may be used for research.

In full recognition of the above considerations and limitations of the laboratory methods and interpretation of results involved, I release the Doctors and Scientists concerned from any liability for injury, either physical or mental and assume all risks inherent.

Witness Signed

Name & Signature & Address Name

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Form G, [Rule 10] (as per PNDT Act)

FORM OF CONSENT FOR PRENATAL DIAGNOSIS

I. . . . . wife / daughter of. . . . .

……………………………… age. years, residing at. . . . .

. . . .

hereby state that I have been explained fully the probable side effects and after effects of the prenatal diagnostic procedures. I wish to undergo the prenatal diagnostic procedures in my interest to find out the possibility of any abnormality (i.e. deformity or disorder) in the child I am carrying.

I undertake not to terminate the pregnancy if the prenatal procedure and any prenatal tests conducted show the absence of deformity or disorders.

I understand that the sex of the foetus will not be disclosed to me.

I understand that breach of this undertaking will make me liable to penalty as prescribed in the Prenatal Diagnostic Techniques (Regulation and Preventation of Misuse) Act. 1994 (57 of 1994)

Date: Signature

Place:

I have explained the contents of the above consent to the patient and her companion named

.... Resident of ....

. . . .

. . . . whose relationship to patient is.. .. .. in a language she /

(they) understand.

Name, Signature and Registration Number of Doctor

Date :

Genetic Clinic, Sir Ganga Ram Hospital, Registration number of Genetic Clinic