



Asiri Centre for Genomic and Regenerative Medicine

Asiri Surgical Hospital, Kirimandala Mawatha, Colombo 5, Sri Lanka
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CONSENT FOR GENETIC TESTING

PATIENT

I consent to give a blood sample for the following reason:

- | | |
|-----------------------------|--|
| Diagnostic gene test | <input type="checkbox"/> |
| Carrier detection gene test | <input type="checkbox"/> |
| Pre symptomatic gene test | <input type="checkbox"/> |
| Chromosome test | <input type="checkbox"/> |
| DNA storage | <input type="checkbox"/> |
| Other | <input type="checkbox"/> Specify:..... |

Name of condition / gene

- I understand that the sample(s) will be stored for use in the future for a short period of time in case I require further tests.
- I understand that in developing and standardising genetic tests it may be necessary to use part of my sample(s) anonymously.
- I understand that sometimes (eg: when chromosome cultures fail to grow) it may not be possible to issue a test result.
- I understand that the test results will be kept confidential and not released to anyone else other than me or my doctor.

Name

SignatureDate

Name

SignatureDate

Parent or guardian (if applicable)

DOCTOR/COUNSELLOR

I,, have explained to the above patient the purpose of obtaining the sample(s) for genetic testing.

Signature Date