Erasmus MC
Universitair Medisch Centrum Rotterdam

To be completed by an employee of the department of Clinical Genetics
Dossiernummer:
Initialen arts:

Consent form for genetic diagnostic testing (gene set/WES/WGS)

Patient*

Surname	
First name	Date of birth

*For trio-sequencing and/or patients under the age of 16, please fill in the details of parents and/or legal guardians.
For trio-sequencing, one completed consent form is sufficient, provided it is signed by both parents .

Surname parent 1	
First name parent 1	Date of birth

Surname parent 2	
First name parent 2	Date of birth

I hereby give permission for my DNA/the DNA of the person for whom I am the legal guardian to be stored and tested by gene set and/or whole exome sequencing (WES) and/or whole genome sequencing (WGS) for the following disorder/condition:
……….....

Incidental findings

During my consultation it was explained that incidental findings will be reported as follows:

- The predisposition to a disorder will be reported if medical treatment or monitoring is possible.
- The predisposition to a disorder will **not** be reported if, based on current knowledge, **no** medical treatment or monitoring is possible.
- If an incidental finding has been identified that presents a high risk of a disorder not for me but for my (unborn) child, this will be reported.

Only to be completed by the applicant in the event of nonconformity from the above agreements

If other agreements were made during the consultation about reporting incidental findings, please list them below:
□ The predisposition to a disorder for which medical treatment or monitoring is possible is **not** reported (= opt-out).
□ The predisposition to a disorder for which, based on current knowledge, no medical treatment or monitoring is possible, **is** reported (=opt-in).
□ If there is a high risk of a disorder for the (unborn) child, this will **not** be reported (=opt-out).

Remarks:

……….....

Future contact

It is possible that new data and information of importance to you could become available in the future. Please indicate whether you wish to be informed about this or not.

□ The Department of Clinical Genetics may contact me in the future regarding new data or information that becomes available.

□ The Department of Clinical Genetics may **not** contact me in the future about new data or information that becomes available.

Scientific research

Your remaining genetic material and/or that of your child can be used (without any personal data) for scientific research on your disorder and related disorders. You will not benefit directly from this, although a researcher might discover something that could be important to your health or that of your family. The doctor will inform you about this.

□ I **give my** consent to scientific research being conducted on my disorder and related disorders.

□ I **do not give** consent to scientific research being conducted on my disorder and related disorders.

Declaration

I have been fully informed both verbally and in writing about genetic diagnostic testing.
I understand that I have the option to change or withdraw my consent at any time.

…………………………………………………………………….	…………………………………………………………………..
Patient's name*	**Patient's signature***
…………………………………………………………………………	……………………………………………………………………
Name of parent 1 / legal guardian*	**Signature of parent 1 / legal guardian***
……………………………………………………………………………………………	…………………………………………………………………………………………
Name of parent 2 / legal guardian*	**Signature of parent 2 / legal guardian***

……………………………………………………………………………………………………

Date

*Patients under the age of 12 are not required to sign: the signature of both parents/legal guardians is sufficient. For patients between the ages of 12 and 16, both parents/legal guardians should co-sign together with the patient, if possible. A signature form for both parents is required for trio sequencing.

Please return the completed consent form in the enclosed return envelope (no stamp required), or send it to:
Erasmus MC, Afdeling Klinische Genetica, Secretariaat Ee2018, Antwoordnummer 55, 3000 WB Rotterdam.
For questions and contact: PHONE: 010 703 6915 FAX: 010 704 3072 MAIL: ervo@erasmusmc.nl