PREVENTION GENETICS

PREVENTIONGENETICS USE ONLY

Test information is available on our website:
www.PreventionGenetics.com

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

PRENATAL HEALTHCARE PROVIDER'S STATEMENT

This statement is required and applies to all cases of ongoing pregnancy.

MOTHER'S INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	MOTHER'S DATE OF BIRTH
			_____ / _____ / _____ MONTH DAY YEAR

My signature below indicates all of the following:

- I take responsibility for the appropriateness of the requested testing.
- I have explained the purpose of the prenatal testing I have requested.
- I have provided appropriate genetic counseling to my patient.
- I have given the opportunity for the patient to ask questions.
- I am responsible for obtaining written or verbal informed consent (ensuring my patient understands risks, benefits and limitations of the testing and the implications of the results).

HEALTHCARE PROVIDER SIGNATURE _____ PRINTED NAME _____ DATE _____

FOR NY SPECIMENS ONLY: Retention of Unused DNA

PreventionGenetics' general policy is to retain all excess DNA from patient testing indefinitely. This allows for easier ordering of additional testing in the future and saves considerable phlebotomy and shipping costs to the patient and healthcare system. Excess DNA specimens can also be used for quality control measures. New York (NY) law requires patient consent in order to retain excess DNA beyond 60 days. If patient specimen was collected in NY and this statement is not signed, excess DNA will be discarded 30 days after testing is completed.

I have obtained consent from my patient(s) for PreventionGenetics to retain unused DNA from all specimens (i.e., fetal, maternal, paternal, proband, etc.) for potential future testing ordered by his/her healthcare provider and for quality control.

HEALTHCARE PROVIDER SIGNATURE ON BEHALF OF PATIENT _____ PRINTED NAME _____ DATE _____