Cerba

GENETICS TESTING
INFORMED CONSENT

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PATIENT INFORMATION	REFERRING PHYSICIAN
First name	Name.....
Last name.....	.....
Maiden name	Address.....
Date of birth.....	.....
Address.....	.....
.....	.....
.....	Tel.: .....
Tel.:	Fax: .....

PHYSICIAN'S STATEMENT AND PATIENT'S INFORMED CONSENT

I, the undersigned ……., Doctor,

certify having seen today **the above-mentioned patient** in order to give her/him the following information:

- There are clinical symptoms/signs to suggest that the patient might carry a genetic change.
- Blood will be used for the purpose of attempting to determine if he/she and/or members of him/her family are carriers of the disease gene, or affected with or at risk to someday be affected by this genetic disease

I, the undersigned, Mrs. …….,

Hereby consent to the sample being taken and this test being performed. I will be given the results of the analysis which will be explained to me by the requesting physician.

Place : Date:

Referring physician's signature: Patient's signature:

CYTOGENETICS
Dr Anne Bazin
Dr Pascale Kleinfinger

MOLECULAR GENETICS
Dr Anne Bazin
Jean-Marc Costa
Dr Pascale Kleinfinger
Isabelle Vinatier

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