CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Université de Montréal

HSJ-0514

CONSENT FOR MOLECULAR GENETIC TESTING (FETUS)

I, _____, born on _____, consent to an analysis of my fetus' genetic material for: karyotype ☐ other test : _____.
On the following fetal sample: amniocytes ☐ chorionic villi ☐ other : _____.

If the test will be performed on a sample collected via an invasive procedure : ☐ amnio ; ☐ CVS

- I have been informed of the risks associated with these procedures, in particular, the **risk of miscarriage**. ____ (initial)
- I have been informed that **the test may have to be undertaken a second time on account** of a lack of cells in the collected sample or contamination from the mother's cells (in the case of CVS). _____ (initial)

In some cases,

- The test results may be difficult to interpret.
  - o I understand that **blood samples from me and my partner** may be needed to help interpret the fetus' results.
  - o I understand that the following results will generally not be reported for the fetus (except in rare situations, after discussion with the ordering medical geneticist)
    - Results with unclear clinical significance
    - Results revealing a carrier status for a recessive disease
  - o I understand that **the implications of the results for the health of my fetus may remain difficult to establish**.

If a CGH (or other genomic test) is performed:
I will be informed of all results **potentially related to the reason** the test was ordered.

In rare instances, it is possible that the test will reveal results that are **not related** to the reason the test was ordered (**incidental findings**). In such a case, I will be informed of incidental findings that, according to current knowledge, could have an **impact on the management of the fetus during pregnancy or the child during childhood, or that could have an impact on a future pregnancy** (X-linked conditions). The laboratory **will not actively look for** this type of result: if my fetus' result is normal, it does not rule out the possibility that genetic change(s) other than those targeted by the test ordered are present.

☐ I want ☐ I do not want to be informed of incidental findings **not known to have any impact on health until adulthood and for which treatment or surveillance is only currently available in adulthood.** I understand this may reveal a genetic change that could have an impact on the health of one of the fetus' parents.

I understand that **a normal result does not completely rule out the possibility that a genetic change is present in my fetus but is undetectable by the method used,** either because the change is in parts of the genome not explored by the test, or because the method used can detect only certain types of changes.

I understand that I will be informed of the test results by the ordering professional and the results will then be available in my medical file.
If similar analyses are conducted on **members of my family**, ☐ I authorize or ☐ do not authorize the use of my test results to help interpret my family members' results.

_____ _____ _____ _____
Signature (patient or legal guardian, if applicable) Date Witness Date

I have explained the proposed DNA analysis to the person who has consented to the test, and I have provided answers to his or her questions.

_____ _____
Signature of the professional Date