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Aneuploidy 13-18-21-X-Y DetectR™ INFORMED CONSENT

- 1. What is Aneuploidy?** Aneuploidy is a change in the number of chromosomes that can lead to a chromosome disorder. The most recognized forms of aneuploidy are the trisomies 13, 18 and 21. A trisomy is the presence of three chromosomes, instead of the normal two.
- 2. What Is The Purpose Of This Test And What Are Its Limitations?** This test provides rapid detection of trisomies 13, 18, and 21 and/or sex chromosome (X and Y) aneuploidies. These conditions account for nearly 2/3 of all chromosome abnormalities identified at the time of amniocentesis, and 85-90% of clinically significant chromosome abnormalities detected in live-born infants. This test is not intended to be used as a stand alone assay for making clinical decisions. The test results are intended to be used in conjunction with conventional karyotyping and other clinical information to confirm a diagnosis of suspected chromosome abnormality and to provide a preliminary result to parents. This assay will not detect chromosome mosaicism, duplications, deletions, or structural rearrangements and does not identify all birth and/or developmental abnormalities.
- 3. What Is Required To Perform This Test?** You or your child will be asked to provide 5 mL of blood, which is equal to about one tablespoon. DNA will be extracted from this blood sample and tested. The only discomfort that you may feel is the stick of the needle in your arm. You may also experience a small bruise at the site of the needle puncture. You will also be asked to provide information regarding your or your child's medical history, which is necessary for proper interpretation of your test result. For prenatal diagnosis, a small amount of fetal cells obtained by amniocentesis is required. These procedures carry a small risk (about 1%) for a loss of the pregnancy. In the unlikely event that you or your child should be injured in the course of being tested, your physician will provide any necessary medical care. However, you would be expected to bear the cost of such medical care. Compensation will not be provided in the event of any injury.
- 4. Is There A Cost For This Test?** This is a routine clinical laboratory test and the results may aid in your or your child's diagnosis; thus, you or your health insurer will be billed for this procedure.
- 5. What Will Happen To The DNA Once The Test Is Complete?** The original sample will be discarded at the end of the testing process or stored not more than 60 days. The DNA will be retained for a minimum of 6 months. In some circumstances, a patient's DNA may be used anonymously as a negative or positive control sample in future testing, but, in this circumstance, all identifiers will be removed prior to be testing and the DNA sample and results obtained will remain anonymous.
- 6. How Will I Obtain Results From This Test?** DNA testing and interpretation of results are complex. The information from this test will be provided in the form of a written report to your physician who will inform you of the results. The laboratory will not provide results directly to patients. Your physician may suggest genetic counseling prior to performing this test or if your results are abnormal. To the extent permitted by law, all of your laboratory records and results are confidential and shall not be disclosed without your written authorization.

I understand and agree that my DNA remaining after testing may be stored for up to 6 months should additional testing be required. *Please initial.*

Patient Attestation of Informed Consent:

My signature below indicates that I have received information about this test, Aneuploidy 13-18-21-X-Y DetectR™ and that I have read and understood the material in this document. I have been given a full opportunity to ask questions that I may have about the testing procedure and related issues. I agree to undergo this testing.

Patient Signature

Date

Signature of Parent/Guardian if Patient is a minor

Print Name of Parent/Guardian

For the Physician:

As the referring physician, I understand the benefits and limitations of this study and have requested that the above-named patient be tested. I attest to the fact that I have provided the patient with the information contained above and fully answered any questions. I believe that the patient understands the information and is voluntarily signing this informed consent.

Signature of Physician/Health Care Professional

Print Name of Physician/Health Care Professional