Please inquire regarding which exons are tested & includes testing for all genes listed above.

For prenatal specimens, please submit maternal blood for MCC Array Comparative Genomic Hybridization (aCGH) 180K + SNP Fluorescent in situ Hybridization (FISH) 

Array Comparative Genomic Hybridization (aCGH) 180K + SNP

For prenatal specimens, please submit maternal blood for MCC

Prenatal Chromosome Microarray
High Resolution Chromosome Microarray (CV, AF, PB or POC)

Please include blood specimen from parents of the proband if available:

Other: 

Pharmacogenetic Tests

Tamoxifen Metabolites, Plasma
CYP2D6 genotyping
SLC01B1 genotyping (e.g. Statin)
Mt Sinai PsA genotyping panel (includes testing for all genes listed above)
Informed Consent for Genetic Testing

I, ______________________________, hereby request genetic testing for me/or my child (name of child if applicable) ______________________, which may include molecular, cytogenetic and/or biochemical analyses. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my child am about to undergo.

I understand that a specimen(s), such as peripheral blood, saliva, cheek swab, dried blood spot, skin biopsy, amniotic fluid, chorionic villi and/or urine sample will be taken from me/my child. I understand that the samples will be used for determining if I/my child have a genetic disease, are carriers of a genetic disease or are more susceptible to develop a genetic disease or medical condition.

The nature of the genetic testing for (test name) ____________________________ has been explained to me and the accuracy of the test and its risks and limitations have been detailed. I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%. I understand that a negative result reduces but does not eliminate the possibility that I/my child carry a mutation(s) in the gene(s) analyzed or in other gene(s) that are not included in the test.

No test will be performed and reported on my sample other than the one(s) authorized by my doctor.

I give consent to have my/my child’s specimen anonymously used by the laboratory for scientific research related to genetic disease and stored for as long as the specimen is useful for such research purposes, not to exceed 10 years, and that I/my child will receive no compensation in connection with such research. I understand that I may withdraw this consent at any time and that my/my child’s specimen will be promptly destroyed.

I understand that this testing may yield results that are of unknown clinical significance and that parental or other relative’s specimens may also be tested to determine whether a specific finding was inherited. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated and this test may detect non-paternity.

I understand that the laboratory may wish to contact me/my child in the future for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my child’s sample(s). I understand that I may notify the laboratory to opt out of such future contact.

The results of my/or my child’s test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.

I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

_________________________________________________________  ________________
Signature of Person Being Tested (or guardian)  Date

_________________________________________________________  ________________
Witness  Date