LMU KLINIKUM DER UNIVERSITÄT MÜNCHEN

CAMPUS INNENSTADT

KINDERKLINIK UND KINDERPOLIKLINIK
IM DR. v. HAUNERSCHEN KINDERSPITAL

Immundiagnostisches Labor
PD. Dr. Dr. F. Hauck, Dr. rer. nat. T. Magg
Universitätskinderklinik
Lindwurmstr.4
80337 München
Tel. 089-4400-52831 / FAX: 089-4400-57759

Patient's Information:

_____ _____
Family name First Name(s)

_____ _____
Date of birth Telephone

_____
Address

_____ _____ _____
Postal code Town Country

Consent form of genetic investigation and storage of diagnostic samples according to the law of genetic diagnostics (GenDG; dated 1.Feb.2010)

Due to the law of genetic diagnostics (GenDG) genetic analysis can only be performed after extensive explanation and written consent of patients. Genetic counseling is also required for prenatal or predictive analysis. With my signature I give my permission to perform the molecular diagnostic of the following disease:

_____ and

my agreement to obtain the specimens of material needed for investigation.
I confirm that I was told that current techniques will not allow the detection of all alterations (mutations) and variations. In addition, the genetic defects are not yet found for a number of diseases. Therefore, the results of these investigations may not lead to therapeutically consequences and/or prognostic prediction for me.
All the information I gave as well as all results of these investigations will be handled under the physician's duty to maintain patient confidentiality. I may withdraw my consent orally or in writing at any stage without any explanation and without any disadvantages.

Please read the following carefully and mark applicable answers

I agree that the results and obtained specimens of these investigations may be kept longer than the legitimated time of 10 years. That way, revisions of the examination result if necessary or desired, or further genetic examinations in order to make a diagnosis are possible.	□ yes □ no
I agree that obtained specimens can be used in a blinded and anonymous manner for scientific reasons in medical research, and that results of these studies can be published in an anonymized way.	□ yes □ no
I agree that the results of the investigation may be disclosed not only to the doctor who initiated this testing but also to other doctors involved in my treatment. Information to other parties such as insurances, employer, and agencies may need my specific agreement.	□ yes □ no
I agree that my results can be used for genetic counseling and diagnostic of family members.	□ yes □ no
I agree that the task of carrying out the examination may be transferred to a collaborating specialist medical laboratory if investigations cannot completely be performed in this laboratory.	□ yes □ no
I agree that the obtained specimens can kept for the purpose of quality control, student teaching, research of the above mentioned disease, and the improvement of diagnostic and treatment in a blinded way.	□ yes □ no

_____ _____ _____
Date Patient's signature / signature of parent or legal guardian Signature of responsible physician

Leiter: Prof. Dr. Dr. C. Klein
öffentl. Verkehr: U6, U3 oder Bus 58 bis Haltestelle Goetheplatz