Consent Form for Genetic Testing in Accordance with the Genetic Diagnosis Act (GenDG)

A fully completed and signed consent form from the patient or their legal guardian is an absolute prerequisite for conducting the genetic test.

Patient name **date of birth**

Clinical symptoms / Presumptive diagnosis / Indication / Clinical question

Please cross out what does not apply:

I consent to the necessary collection of sample material and the genetic testing related to the above-mentioned question.

If necessary, I consent to the forwarding of the test request and the collected data to a specialized facility.

Depending on the test request and in order to achieve high sensitivity, a comprehensive DNA test may be necessary.

In the course of genetic analyses, information may be obtained that is not related to the test request but may nevertheless be of medical significance to me or my relatives (incidental or additional findings).

If test results are positive,

I would like to be informed of any additional findings: ☐ **Yes** ☐ **No**

(If no explicit selection is made, it will be assumed that "No, I do not wish to be informed.")

I understand that I have no right to expect such additional findings to be complete or updated in the future.

I have been informed that, in accordance with health insurance requirements, previously unidentified DNA variants will be documented in a publicly accessible database.

I consent to the use of excess test material and the collected data in encrypted (pseudonymized) form for research into the causes and for the improvement of treatment of genetically determined diseases and those results be published in scientific journals. To this end, I hereby transfer the material / data to the Laboratory for Translational Oncology, Department of Internal Medicine II, Tübingen. I consent to the retention of test results and records beyond the prescribed period of 10 years. I consent to the storage of examination material for the purpose of verifying the results and for future diagnostic possibilities. If necessary, the results of the examination may be used for the consultation and examination of family members.

I consent to the disclosure of the findings to collaborating and treating physicians and to the International Registry for Severe Chronic Neutropenia (SCNIR).

(If you do not consent to disclosure to the SCNIR, please delete this passage.)

Additions:

My treating physician has explained to me in a personal consultation the significance and implications of the diagnostic procedures, and in particular the purpose, nature, scope, informative value, and consequences of the examinations. I was given the necessary time to consider this. I may revoke this consent in whole or in part at any time.

Place, Date

Signature of Patient/1st Legal Representative* **2nd Legal Representative***

Signature of the Informing Physician

Stamp of the Informing Physician
(Name in block letters)

(*For children, both parents with custody must give their consent and sign, or a power of attorney must be provided if not all parents with custody are present.)

Sample Submission: Department of Internal Medicine II, West Ward Building/Level 02, Room 528, Prof. Dr. J. Skokowa, Otfried-Müller-Str. 10, 72076 Tübingen
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