Consent Form for Exome Sequencing

Patient
Parent or Guardian

Surname Given Name(s)	Surname Given Name(s)
Address	Address
Zip code	Zip code
Date of Birth	Date of Birth
Telephone	Telephone

To be completed by the Patient/Guardian

1. I wish that DNA from **me/ my child / person under my legal guardianship** will be stored and tested by exome sequencing for the following condition:

---

1. By signing this consent form I confirm that I have been verbally and in writing informed about whole exome sequencing and its possible findings.

1. I agree with the following report policy.
   a. I will be informed about all findings relevant to the condition in question which are identified by exome sequencing.
   b. In case there is a finding that is not related to the original question (an unsolicited finding), an independent committee of experts will decide whether the unsolicited finding is of immediate importance. Unsolicited findings that are directly relevant to my health and / or the health of my child, for any subsequent pregnancies and / or family members will be discussed (it is expected that the above will rarely occur).

1. I understand that I have the ability to withdraw my consent at any time without influencing **my management /the management of my child/my ward**.

1. I have had the opportunity to ask additional questions I and am satisfied with the explanations.

Print name of Patient	**Signature of Patient**

Print name of Guardian	**Signature of Guardian**

Print name of Health Professional	**Signature of Health Professional**

Date: ----------