General University Hospital in Prague and
Charles University – First Faculty of Medicine
INSTITUTE OF INHERITED METABOLIC DISORDERS
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Physician's statement

Patient's first name: ……

Patient's family name: ……..

Date of birth: ……..

I hereby confirm that I have explained to the patient (or his/her legal guardian) the purpose, nature, anticipated benefits and potential risks of the genetic diagnostic testing for:

_____

in an appropriate way that he/she can understand.

I have also informed him/her about possible results, their interpretation, and the consequences that may arise, in case the testing had failed or was uninformative. The results of the genetic diagnostic testing will remain confidential without access for any third party unless a written consent of the patient or his/her legal guardian is given.

Patient (his/her legal guardian) decided that the remaining sample after the analysis:

a) can be stored in our Institute and may be used for further testing to establish a diagnosis according to possible new methods that may be available in future with respect to the above mentioned disorder

yes no

b) can be stored and may be used without disclosing personal data (i.e. in anonymous form) for scientific purposes or for laboratory quality management purposes.

yes no

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(Signature referring physician) (Place/Date)

Referring physician:

First and family name:
Institution:
Address:
Phone number:
Fax number:
E-mail: