

**Documentation of the clarifications / genetic counselling
before / after genetic testing according to Gendiagnostikgesetz [Genetic Diagnosis Act]**

Facility / physician	Patient data (if necessary, label)
	Name _____ First Name _____ Born on. _____ Tel. _____ Address line _____ Postcode _____ Place _____

1. Offer of genetic counselling (mandatory in case of predictive or pre-natal diagnostics)	
I have read, understood and received a copy of the information leaflet for clarification/genetic counselling before/after genetic testing according to GenDG [Genetic Diagnosis Act].	<input type="checkbox"/> yes <input type="checkbox"/> no
I would like to make use of the genetic counselling offer before genetic testing:	<input type="checkbox"/> yes <input type="checkbox"/> no
I would like to make use of the genetic counselling offer after the results of genetic testing are available:	<input type="checkbox"/> yes <input type="checkbox"/> no
Waiver: I decline the offer of genetic counselling after receipt of the written information about the contents of the counselling.	<input type="checkbox"/> yes <input type="checkbox"/> no
Comments:	
Place, date:	Patient's signature or legal representative

2. Confirmation of concluded clarifications and/or genetic counselling (delete as applicable)	
The disease / disorder / diagnosis....., its genetic background, prophylaxis/prevention/treatment possibilities as well as purpose, nature, scope and information value of a possible genetic diagnostic including the risks attached to the taking of samples and/or the tests have been made sufficiently clear to me and counselling in these matters was adequate.	<input type="checkbox"/> yes <input type="checkbox"/> no
I was advised that I am entitled to withdraw my agreement in whole or in part without giving reasons and without any penalties resulting from this withdrawal. I know that I have the right not to be informed of the examination result(s) (right not to know). I was advised that I can stop the commenced examination procedure until the communication of the results at any time and that I can demand the destruction of all of my examination material including all components extracted from it as well as of all results and findings obtained so far.	<input type="checkbox"/> yes <input type="checkbox"/> no
I agree to the findings of the genetic testing being sent to: <ul style="list-style-type: none"> ▪ My general practitioner: Dr. ▪ My gynaecologist: Dr. ▪ Dr.: ▪ Dr.: 	<input type="checkbox"/> yes <input type="checkbox"/> no
Place, date of clarifications/genetic counselling before the examination:	Patient's signature or legal representative:
Place, date of genetic counselling after presentation of results:	Patient's signature or legal representative:

3. Documentation by the consultant clarifying/counselling according to GenDG [Genetic Diagnosis Act] (use additional sheet if necessary))	
Anamnestic characteristics:	
Documentation of clarification/counselling contents before examination: <input type="checkbox"/> genetic background <input type="checkbox"/> risk of repetition <input type="checkbox"/> prophylaxis/prevention/treatment possibilities <input type="checkbox"/> purpose, nature, scope and information value of examination <input type="checkbox"/> risks attached to the taking of samples and/or the tests <input type="checkbox"/> Other:	Documentation of clarification/counselling contents after presentation of results: _____ <input type="checkbox"/> genetic background <input type="checkbox"/> risk of repetition <input type="checkbox"/> prophylaxis/prevention/treatment possibilities <input type="checkbox"/> purpose, nature, scope and information value of examination <input type="checkbox"/> risks attached to the taking of samples and/or the tests <input type="checkbox"/> Other:
Procedure:	Procedure:
Place, date:	Place, date:
Signature of the physician responsible according to GenDG	Signature of the physician responsible according to GenDG