



## Informed Consent for Pharmacogenetic Testing

The following information explains both the purpose and benefits of pharmacogenetic testing, as well as your rights as a patient. Please discuss any questions or concerns you might have with your physician before consenting to the test. If, after reading this form, you agree to testing, please sign and date the testing requisition.

Pharmacogenetic testing can assist your physician in prescribing drugs that are most likely to work for you, based on your unique genetic profile. In addition, pharmacogenetics testing can help your physician make critical adjustments to the dosages of some medication, as well as avoid prescribing combinations of drugs that may cause you to experience an adverse reaction.

The testing itself is quick and painless. A physician or nurse will use sterile swab(s) to collect cells from the surface of the skin inside of your cheek. Your samples will then be sent to a laboratory for analysis. Once available, the results will be sent to your physician, who may then use the results to make adjustments to your treatment plan.

Your signature indicates that you have consented to the below testing and authorized Crestar Labs to perform the below testing.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

I have educated the patient on the purpose & nature of the ordered pharmacogenetics testing.

Ordered Test \_\_\_\_\_

Purpose of Test \_\_\_\_\_

Ordering Physician/Provider \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_