Folate Metabolism Genetic Screening
Consent Form

Clinical Information (Record by health care provider) **Sample No.**_____

Medical Record No.		Collection Date (d/m/y)	/ /
Hospital/Clinic		Physician (Signature)	
Specimen Type	☐ Blood, 2 mL ☐ Amniotic Fluid, 10 mL ☐ Chorionic Villus Sampling (CVS) ☐ Umbilical Cord Blood, 2 mL		

Patient Information (Completed by the patient)

Name		Gender	☐ Male ☐ Female
ID/Passport No.		**Date of Birth (d/m/y)**	/ /
Mobile Phone No.		**Phone No.**	
Address			
Pregnancy	☐ No ☐ Yes, Estimated Date of Confinement (d/m/y): / /		☐ Singleton ☐ Multiple

I, the undersigned, understand the Folate Metabolism Genetic Screening serve as an identification of the risk of abnormal folate metabolism. I hereby fully understand, agree and undertake the following:

1. In rare cases, poor sample quality (for example, due to coagulation, hemolysis, or insufficient sample volume) will require a repeat sample to ensure the accuracy of the Test.
2. Folate Metabolism Genetic Screening involves the use of polymerase chain reactions (PCR) combined with DNA sequencing to validate the common C677T variant in the MTHFR gene. Consequently, this Test determines the risk of abnormal folate metabolism in order to reduce the occurrence of neural tube defects in the newborn and prevent related complications during pregnancy.
3. The accuracy of this Test is not affected by food intake, age, gestational age, parity, or multiple pregnancy.
4. I ☐agree / ☐ do not agree to allow the remainder of my sample to be used for research purposes. (Lack of response indicates consent.)
5. According to my situation, the physician has answered all my questions and adequately explained to me (included but not restricted to the information about the necessary, process, potential risk and successful rate of this Test as well as the risk of other screening tests).
6. I fully understand the above terms, statements, and declarations, and I agree to have this Test performed at my own expense. I understand and accept that this Test may be the most appropriate choice at this time, but it cannot guarantee the prevention of the tested disorders.

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Signature, Date (dd/mm/yyyy)