SOFIVA Carrier Scan Consent Form

SOFIVA GENOMICS www.sofivagenomics.com T: +886-2-23826615	☐ **SOFIVA Carrier Scan v1.0** ☐ **SOFIVA Carrier Scan v2.0** ☐ **SOFIVA Carrier Scan v3.0**
Hospital / Clinic:	**Physician (Signature):**

Patient Information

Name		Gender	☐ Male ☐ Female
ID / Passport No.		**Date of Birth**	(dd) (mm) (yyyy)
Phone No.		Nationality	
Address	☐☐☐-☐☐		
Pregnancy	☐ No ☐ Yes, Gestational Age:_____weeks		
Spouse Tested	☐ No ☐ Yes, Name: _____ , Result: _____		

Clinical Information

Medical Record No.		**Collection Date**	(dd) (mm) (yyyy)
Specimen Type	☐ Blood(EDTA tube) ☐ Other _____		
Have the genetic mutations in your family been confirmed?	☐ No ☐ Yes, Please briefly describe the medical signs or symptoms:		

I, the undersigned, understand the SOFIVA Carrier Scan clearly. I hereby fully understand, agree and undertake the following:

1. This test utilizes next generation sequence and capillary electrophoresis to analyze specific pathogenic hotspots. This test is not able to detect the following types of mutation: copy number variation of chromosomes, gross deletion or duplication of genes, recombination, inversions, balanced and unbalanced translocations, uniparental disomy, and low level mosaicism.
2. This test mainly screens for the pathogenic hotspots of specific single gene disorders. Non-common mutations for those disorders and unselected single gene disorders are not included in the test. Therefore, the tested individual cannot be completely ruled out the possibility of being a carrier.
3. Some diseases may have multiple mechanisms. This test analyzes the hotspot regions of common genetic mutations for the specific single gene disorders. Therefore, the detection rate depends on the number of hotspots selected for each disorder.
4. When the test result shows that you are a disease carrier, you may have some abnormal conditions or carry defect genes for genetic disorders. It is recommended to consult a genetic medicine specialist to fully understand the meaning and content of the report.
5. In rare cases, the sample will need to be recollected due to the poor sample quality caused by coagulation, hemolysis, or insufficient specimen volume.
6. I hereby agree that the hospital/clinic and Sofiva Genomics may collect, process or use my personal information such as medical records, medical treatment, genetic information and health examination records under the specific purpose of medical care, health treatment etc.
7. I ☐agree / ☐do not agree to allow the remainder of my sample to be used for research purposes (Lack of response indicates consent).
8. The physician has answered all my questions and adequately explained about the test (included but not restricted to the information about the importance, process, potential risk and successful rate of this test as well as the risk of choosing other screening tests).
9. I fully understand the above terms, statements, and declarations, and I agree to have SOFIVA Carrier Scan performed at my own expense. I understand and accept that SOFIVA Carrier Scan may be the most appropriate choice at this time, but it cannot guarantee the prevention of the tested disorders.

_____

Signature, Date (dd/mm/yyyy)

Copy 1: Laboratory Retain (White) Copy 2: Hospital/Clinic Retain (Blue) Copy 3: Patient Retain (Red)