



## Medical Services Clinic

Department of Laboratory  
Medicine

Section of Medical Genetics

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Ref.: Biotechnology Act

Our ref.: Disease/issue \_\_\_\_\_

### **Declaration of informed consent for studies involving next-generation sequencing**

Next-generation sequencing studies have diagnostic and/or therapeutic goals. Next-generation sequencing involves studying larger areas of the genome than for the sequencing of individual genes. There is therefore a possibility that we will make incidental findings that could have implications for your health. By incidental findings, we mean changes in the DNA that we are not looking for. In other words, it is possible that we will discover other diseases besides the one we are specifically searching for. Next-generation sequencing can be used in presymptomatic testing, predictive testing and genetic testing to determine carrier status for hereditary diseases that first appear in future generations.

- ✓ I have received comprehensive genetic counselling from the Section of Medical Genetics, Telemark Hospital HF, regarding the disease that occurs in my family. I have also received counselling on presymptomatic testing, predictive testing and genetic testing to detect or rule out carrier status.
- ✓ I have had the opportunity to ask questions, and I have understood the counselling and the answers to my questions.
- ✓ I agree for samples taken from me to be studied and kept by the Section of Medical Genetics, Telemark Hospital HF.
- ✓ I agree that data from the analyses can be stored and used in the interpretation of other tests.

### **Regarding information on the results of the analysis and the right not to know**

#### **(Circle one of these options):**

1. I wish to receive information only about those results that can be linked to the issue addressed by the study
2. As above (point 1), and in addition I wish to receive information about any incidental findings regarding diseases for which there is an established treatment in Norway
3. As above (point 1), and in addition I wish to receive information about any incidental findings that could have implications for my health

\_\_\_\_\_  
Place, date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name in capital letters

\_\_\_\_\_  
Date of birth