INFORMED CONSENT

PHYSICIAN:

I, _________________________, have supplied information to the patient regarding phamacogenetics testing. The patient, _________________________, has given consent for this testing to be performed. This test looks for mutations in genes that are known to be associated with metabolism of drugs. The purpose of this test is to guide your doctor to select the right drug faster and optimize drug therapy. I confirm that this genetic test panel includes genes and variants based on the recommendations of the Clinical Pharmacogenetics Implementation Consortium (CPIC) and Dutch Pharmacogenetics Working Group (DPWG) and the FDA's work group guidance and will be used to help predict how the patient may respond to drugs. Based on the results of this test, I may make changes to the type of drug that I prescribe, or to the amount of a drug that I prescribe to the patient. I understand that the PGxOnePlus™ test is highly accurate.

By signing below, I confirm that I have explained the purpose of this test, the procedures, and the benefits, risks, and limitations that are involved in testing to the patient. The patient has been given the chance to ask questions about this test and offered genetic counseling. The healthcare provider understands that the patient wants to have this testing done. I understand that the DNA testing is not a substitute for clinical monitoring.

X _________________________ **PHYSICIAN SIGNATURE**

_________________________ **DATE**

_________________________ **PRINTED NAME**

PATIENT:

Your doctor has ordered one or more of the following tests: - PGxOnePlus™ test is a DNA sequencing assay used to identify DNA variants in 50 genes that can affect how you will respond to a variety of medications. The test is highly accurate (> 99% specificity and sensitivity) but rare variants in other areas of these genes that could affect drug responsiveness may not be detected.

Results from this test(s) are treated with complete confidentiality and reports rendered only to you and your physician. Your samples will be destroyed after testing unless you specifically authorizes their use in research or commercial applications (see check boxes below).

I have read this consent form or have had the form read to me. I have been given a copy of this consent form. I have been given the chance to ask questions before I sign this consent form. I have been told that I can ask other questions at any time. I want to have this genetic test done.

Please indicate how you want your samples and information to be used:
(New York resident's specimens will be destroyed after 60 days unless checked yes)

I allow my sample DNA and information to be used for research. ☐ Yes ☐ No

I allow my sample and information to be used for commercial products. ☐ Yes ☐ No

X _________________________ **PATIENT SIGNATURE**

_________________________ **PRINT NAME**

_________________________ **DATE**

X _________________________ **SIGNATURE OF AUTHORIZED REPRESENTATIVE**

_________________________ **PRINT NAME**

_________________________ **DATE**

_________________________ **RELATIONSHIP**