Waiver of Genetic Carrier Screening or Other Genetic Testing

Fertility and Reproductive Medicine Center (FRMC)
Washington University Physicians and Barnes-Jewish Hospital

I, _____ , (DOB: _____) and

☐ my spouse/partner, _____ , (DOB: _____)
OR
☐ Not applicable (no partner)

have been informed by the clinical staff of Washington University Fertility & Reproductive Medicine Center that genetic carrier screening or another genetic test has been recommended for me and/or my partner.
I/We understand the following:

- Genetic carrier screening is a type of DNA test to determine whether someone is at increased risk to have a child with certain genetic diseases. The American College of Obstetricians and Gynecologists (ACOG) and the American College of Medical Genetics (ACMG) have set forth recommendations for routine carrier screening for certain genetic diseases, some of which are ethnicity dependent, for all individuals or couples who are planning to conceive. Consequently, the Washington University Fertility & Reproductive Medicine Center recommends genetic carrier screening for all patients.
- It is common for individuals to be a carrier for one or more genetic conditions. As carriers are typically asymptomatic, a negative family history (including healthy children from previous pregnancies) cannot exclude an individual from being a carrier for a genetic condition. Genetic carrier screening may include, but is not limited to, testing for cystic fibrosis, spinal muscular atrophy, Fragile X syndrome (females only), alpha thalassemia, beta hemoglobinopathies, Tay-Sachs disease, Canavan disease, and familial dysautonomia.
- When both the individual contributing the egg AND the individual contributing the sperm are carriers of the same autosomal recessive condition, there is a high risk (25%) of having an affected child with each pregnancy. In this case, certain reproductive options may be available to reduce the chance of having an affected child.
- When a female is a carrier of an X-linked condition, there may be a high risk of having an affected child, regardless of the male partner or sperm donor's genetic status. In this case, certain reproductive options may be available to reduce the chance of having an affected child.
- Individuals with a family history of a specific genetic condition may require specialized genetic testing (such as targeted variant analysis) to determine if he/she is at risk to have a child with the same condition.
- **Without genetic carrier screening, it cannot be determined whether there is an increased risk of having a pregnancy/child affected with a genetic condition.**

The risks, potential benefits of and alternatives to this treatment or procedure have been explained to me/us by my/our physician and staff. I/We understand the explanation that has been given to me/us. I/We have had the opportunity to ask any questions I/we might have and those questions have been answered to my/our satisfaction. Any future questions I/we have may be addressed to my/our treating physician or genetic counselor (314-286-2400).

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I/We have been given ample opportunity to discuss the possible risks and complications of going forward with my/our cycle with my/our physician. By my/our signature(s) below, I/we hereby accept these risks and choose to proceed with the procedure without the recommended genetic test(s). I/We will not hold Washington University, the Washington University Fertility and Reproductive Medicine Center, or their physicians or staff liable for any adverse condition(s) or consequences that may arise from my/our decision.

I/We understand the recommendation for genetic testing and have been informed about the potential risks for genetic condition(s) in my/our offspring. By my/our signature(s) below, I/We hereby decline the following genetic testing against the medical advice of my/our physician:

☐ **Genetic carrier screening**
☐ **Carrier screening for ethnically-relevant diseases**
☐ **Other**: _____

SIGNATURE(S):

Patient:_____ _____ _____
Printed Name Signature Date

Witnessed by a Fertility & Reproductive Medicine Center clinical staff member (photo ID of patient required):

Witness: _____ _____ _____
Printed Name Signature Date

If applicable:
Partner:_____ _____ _____
Printed Name Signature Date

Witnessed by a Fertility & Reproductive Medicine Center clinical staff member (photo ID of partner required):

Witness: _____ _____ _____
Printed Name Signature Date