

University of Colorado at Denver and
Health Sciences Center,
Anschutz Medical Campus

**BIOCHEMICAL
GENETICS
LABORATORY**
Department of Pediatrics

**Bldg. RC-1 North, Room P18-
4403C
12800 East 19th Avenue
Aurora, CO 80045**

Phone: (303)724-3826

Fax: (303)724-3827

<http://www.uchsc.edu/bglab>

PATIENT NAME:
DATE OF BIRTH:
FEMALE MALE

HOSPITAL NAME:
ADDRESS:

PHONE:
FAX:

PHYSICIAN:
COLLECTION DATE: TIME:

I REQUEST PRENATAL DIAGNOSIS FOR:

(GENETIC CONDITION)

Prenatal Diagnosis Consent Form

I give my consent to have my fetus' sample sent to the UCHSC Biochemical Genetics Laboratory for biochemical genetic testing for the genetic condition named above. I understand the tests that will be performed are specific only for the genetic condition named above. My signature below constitutes my acknowledgement that the principles, benefits, risks and limitations of this biochemical genetic testing have been explained to my satisfaction by a physician/genetic counselor, and I have had my questions answered.

I further understand that any disputes that arise in relation to the testing shall be governed by the laws, rules and regulations of the State of Colorado, as are now in effect or as may be later amended or modified without reference to the choice of law or rules of any state. I do now submit to the exclusive jurisdiction and venue of any court having subject matter jurisdiction located in the City and County of Denver, State of Colorado, including the United States District Court for the District of Colorado, in the event of any litigation concerning the testing and regardless of where this consent is executed or where I reside.

Signature of Patient or Legal
Guardian:

_____ (date)

Printed Name of Legal
Guardian:

Relationship to Patient:

Physician/Genetic Counselor:

I have explained this biochemical genetic testing and its limitations to the patient or legal guardian and answered all questions.

Signature: _____

Date: _____