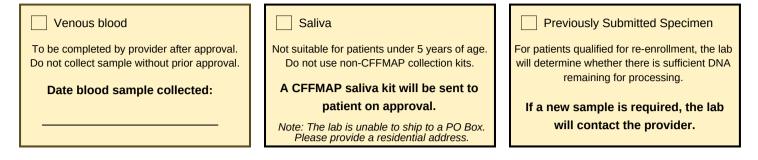
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- Mu	utation Analysis Program† Er	rollment Fo	orm	Johns Hopki Genomics - D
The Johns Hopkins Genomics DNA Diagnostic Laboratory (JHGDDL)				
	<b>†Funded by the Cystic Fibrosis Fo</b>	undation		Sample Intak Room 245
Fax completed form	ns to 410-367-3266. For questions, ca	II the JHGDDL	_ at 833-818-2750.	Baltimore, MD 2
All fields must be complete and legible.	Provider and patient stamps or stickers a	re <i>not</i> valid. Info	prmation must be type	d or handwritten
*MAP Authorization #	: Date:		For JHGDDL U	lse Only
•	atient's first enrollment, or whether th visit the Program website for eligibilit	•	•	nt. Please
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### **Sample Collection** Please select the type of sample to be submitted for testing.



# **Mutation Analysis Program Informed Consent**

### Provider Consent: Read and Sign

I certify that I am the referring provider for the patient identified above, and have assisted the patient in completing this form. I certify that the patient identified above has a confirmed or strongly suspected CF diagnosis. I also understand that the Mutation Analysis Program (MAP) is not intended to be used to diagnose patients with CF, but rather used to identify the patient's unknown genetic variants(s). I certify that I have discussed the purpose of this genetic testing with the patient and explained to the patient that the testing may take up to three months to complete.

Signature of Provider (Required)

Signature Date (Required)

### Patient Consent: Read and Sign

I understand that my physician is requesting the Johns Hopkins Genomics DNA Diagnostic Laboratory (JHGDDL) to perform the Mutation Analysis Protocol on me/my dependent, and that my physician may provide a limited amount of health information with the request. The purpose and accuracy of this testing have been reviewed by my health care provider and my questions about these issues have been answered. I understand that in most cases, a negative test result does not necessarily rule out a hereditary condition. Results of DNA testing should be considered with the results of other types of testing and clinical evaluation. Test results may disclose non- paternity or other genetic conditions. No clinical tests other than those authorized will be performed; however, any remaining sample may be used for quality control purposes or research after de-identification. My physician will receive a clinical report, but the laboratory cannot guarantee turn-around time or that a result will be obtained on any sample. Release to other parties requires written consent of the patient.

## I have read and agree to the Program Informed Consent section above.

-	Patient Name (Printed)	Date of Birth (MM/DD/YYYY)	
×	Signature of Patient/Parent/Guardian (Require	Signature Date (Required)	
-	Parent/Guardian Name (Printed)	Relationship to patient	
woul	d describe my race/ethnicity as (please selec	ct all that apply):	
	Black, African American, or of African descent East Asian Middle Eastern, Southwest Asian, North African Hispanic, Latino/Latina/Latinx Native American, Alaska Native, First Nations	<ul> <li>Native Hawaiian, Pacific Islander</li> <li>South Asian</li> <li>Southeast Asian</li> <li>White</li> <li>Other:</li> </ul>	