Ambry Genetics®

Patient Consent Idiopathic Pulmonary Fibrosis Diagnostic Test

Test Purpose: I desire that **I** or **my child** (please circle appropriate) _____ have molecular genetic testing to ascertain if I/they carry mutation(s) in one of the genes thought to be responsible for development idiopathic pulmonary fibrosis (IPF). This testing is being pursued because I/my child have (has) symptoms and/or clinical testing which according to my physician suggests a diagnosis of interstitial lung disease. A supplemental disease description sheet is available from Ambry Genetics.

Test Method: The blood, body fluid, or tissue specimen submitted is required for isolation and purification of DNA for molecular genetic testing.

Test Results: I understand that due to the complexity of DNA based testing and the important implications of the test results, these results will be reported only through the patient's designated physician(s) or genetic counselor (where allowed) and that I must contact my provider to obtain the results of the test. The test results, in addition, could be released to all who, by law, may have access to such data.

I understand that early research studies have shown this gene testing may reveal disease-causing mutations in approximately 10% of individuals with familial IPF. Other, as yet to be identified genes may also be involved in the pathogenesis of IPF. Therefore, the results of the molecular genetics test may be one of the following:

Positive Testing revealed a mutation that is either clearly deleterious to gene function, or has been reported in the medical literature to be disease causing.

No abnormality Testing failed to find any significant abnormality in the genes. This does not preclude the possibility that a mutation does exist in this gene, which was not identified by the method used. Neither does it indicate that the clinical diagnosis of IPF is incorrect.

Novel variant Testing revealed a change in one of the genes tested, however it is not known whether this change causes decreased function of the gene leading to disease. It is possible that, as new information becomes available, certain novel variants will be determined to be either disease causing, or a benign normal variant.

I understand that the results of this testing could have implications to other members of my family as to their risk of developing IPF. Familial IPF is believed to be incompletely penetrant, meaning that not all individuals who carry a deleterious mutation will develop the disease. Development of disease may also depend on additional factors such as cigarette smoking. My family members or I may wish to seek genetic counseling and/or further discussions with my physician with regard to these implications.

I understand the limitations of these results: the test results could be based upon probabilities, and may not provide a 100% definitive conclusion to either genetic disease predisposition or manifestations. I understand that the molecular genetic test may not generate results and that an additional blood, body fluid, or tissue sample may be needed to obtain accurate results. I understand that the molecular genetic test may not generate accurate results for the following reasons: sample mix-up, samples unavailable from critical family members, maternal contamination of prenatal samples, inaccurate reporting of family relationships, or technical problems, but not limited to these.

Ambry's Rights: Ambry reserves the right to: 1) suggest additional molecular testing if it would help in resolving the patient's clinical genotyping, 2) report additional testing results (other than requested) if they are clinically relevant to the patients and their families, and 3) refuse testing if one of the conditions in the Patient Consent form is not met.

NY STATE RESIDENTS ONLY:

☐ I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

I have read or have had read to me all of the above statements and understand the information regarding molecular genetics testing and have had the opportunity to ask questions I might have about the testing, the procedure, the risks, and the alternatives prior to my informed consent. I agree to have the molecular genetic testing.

Patient Signature	Patient Name (please print)	Date

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