









 $A \ nonprofit\ enterprise\ of\ the\ University\ of\ Utah\ and\ its\ Department\ of\ Pathology$

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EARLY-ONSET ALZHEIMER'S DISEASE (AD) TESTING INFORMED CONSENT

Patient Name:	Date of Birth:
Sex Assigned at Birth: \square Female \square Male \square Intersex	Gender Identity (optional): □Female □Male □
Symptoms: 🗆 No 🗆 Yes If yes, describe:	Age of onset:
Is there a family history? ☐ No ☐ Yes	
If yes, describe relative's relationship to patient:	Age of onset:
Was DNA testing performed on a relative? \square No \square Yes	If yes, describe variant identified:
	after personal identifiers are removed. You may request disposal of your sample by calling ARUP Laboratories at 800-242-2787 ext. 3301. Note: All New York samples will not be used for research or quality assurance and will be destroyed automatically within 60 days of collection. In cooperation with the National Institutes of Health's effort to improve understanding of specific genetic variants, ARUP submits HIPAA-compliant, deidentified (cannot be traced back to the patient) genetic test results and health information to public databases. The confidentiality of each sample is maintained. If you prefer that your test result not be shared, call ARUP at 800-242-2787 ext. 3301. Your deidentified information will not be disclosed to public
Patient/Guardian Printed Name Signa	ature Date
Ordering Provider/Genetic Counselor: I have explained the risks patient/guardian.	s, benefits, and alternatives of this genetic test to the
Provider/Genetic Counselor Printed Name Signa	ature Date