

SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
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(406) 444-7532, (800) 447-6614, fax (406) 444-1022
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Dear Health Care Professional,

You have requested the presymptomatic testing of your patient for Huntington Disease (HD). This letter is intended to (1) alert you that adverse outcomes are possible, (2) inform you of the availability of reference materials on presymptomatic HD testing, (3) document that you are aware of the American Academy of Neurology (AAN) recommendations and practice guidelines for presymptomatic HD testing, and (4) confirm your intention to incorporate this information into the care and management of your patient.

As you know, presymptomatic genetic testing of your patient for HD has potential benefit and clinical utility. Oftentimes underappreciated, however, are the possible types of adverse outcomes and their severity and duration. The AAN and the Huntington Disease Society of America (HDSA) have published recommendations and practice guidelines to inform clinicians of the issues surrounding the presymptomatic testing of individuals for HD, with the goal of optimizing benefits and minimizing adverse outcomes.

Recognition of this information and its application to your patient's care and management IS REQUIRED BY ALL CLINICAL LABORATORIES PRIOR TO PREDICTIVE HD TESTING.

Please read and sign the attestation below, and return this letter to Shodair Genetics Laboratory. **Our fax number is (406) 444 1022.**

Thank you for you cooperation in this matter. Testing of your patient's specimen will begin as soon as the signed attestation is received.

I am very aware of the information presented in the AAN and/or HDSA Recommendations and Practice Guidelines regarding the presymptomatic testing of individuals for HD, and will incorporate this into the care and management of my patient as I deem appropriate and consistent with the practice of my profession.

Clinician's signature

Date

Printed Clinician name

Patient name

Patient date of birth