Neuberg DIAGNOSTICS | CENTER FOR GENOMIC MEDICINE

DNA EXTRACTION AND STORAGE FORM

Name	
Lab ID	
Test Requested	DNA extraction and storage
Sample type	EDTA blood/ CVS/ Amniotic fluid/ POC/ Tissue/ Other (Specify)
Sample Received Date	
DNA Extraction Date	
Referring Clinician	
Tests done at NCGM / Date	[NGS/ CMA/ Sanger/ MCC/NONE]

DNA Extraction QC Report:

This report summarizes the information on the DNA Sample Quality Check (QC) done using Nanodrop 1000.

Lab ID	A260/280 RATIO	QUBIT (ng/µL)	Elution Volume (µL)	QC (Pass / Fail/ Suboptimal)

(Please Note: 3ul was used from the extracted DNA volume for the quality check)

Result Interpretation Table

	A260/280 RATIO	QUBIT (ng/µL)	Elution Volume (µL)
QC Pass	Between 1.5-2.2	10ng/uland above	25ul and above
QC Suboptimal	Between 1.3-1.5 and between 2.2 - 2.4	Between 5-25ng//ul	Between5-25µl
QC Fail	Below 1.3 and above 2.4	Less than5ng/ul	Less than 5ul

Signature of
(Biobank Repository in Charge)

DNA RETRIEVAL REQUEST AND CONSENT FORM

This document is to serve as a consent and a request to retrieve the DNA stored for the below mentioned individual.

I, the undersigned, Mr/Mrs/Miss -- , request the retrieval of the stored DNA sample of --- Lab ID ------------------------------ from Neuberg Center for Genomic Medicine (NCGM). The intention of this retrieval is to perform further testing at -------------------------- (lab or facility) as prescribed by the referring clinician.

Name of lab and address where the DNA has to be sent:

As the requester,

- I understand that the DNA can only be retrieved once and within one year from the date of DNA extraction and storage at the NCGM facility with a service fee of Rs 500/-
- I understand that NCGM will store a minimum DNA sample aliquot (non-retrievable) for any future requirements following the retrieval for myself/my ward for QA purposes.
- I understand that even with appropriate processing and storage, the quality and quantity of DNA may have degraded over time. I have been made aware that this is a possibility in any DNA storage process.
- I understand that any further genetic testing performed on the retrieved DNA (at another facility) will require a separate consent.
- I understand and consent that NCGM will not be held liable to any challenges that may arise by testing the DNA sample at another facility.
- I understand that I will provide my and/or my ward's proof of identification to ensure accuracy in DNA retrieval and delivery.
- I understand that NCGM and its employees have complied with the PCPNDT act. It is my responsibility to query the lab performing further testing about their compliance with the law.
- I CONSENT that NCGM may use the residual DNA for de-identified research purposes

Request Date : --
Name of Patient/Guardian: --
Signature of Patient/Guardian: ------------------------------------ (Relationship to Patient: ------------------------------)
Name of Referring Doctor: --
Signature of Referring Doctor: --
Stamp of Referring Doctor:

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