

COMPOUND AUTHORIZATION AND ADOLESCENT ASSENT
FOR PARTICIPATION IN A RESEARCH PROJECT
YALE UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENTS OF PSYCHIATRY AND CHILD STUDY CENTER

Title: Genetic and molecular studies of developmental neuropsychiatric disorders associated with cognitive and behavioral impairment.

Principal Investigator: Thomas Fernandez, MD
Abha Gupta, MD, PhD
Yale Child Study Center
230 S. Frontage Rd
New Haven, CT 06520

Study Sponsors: The Simons Foundation Autism Research Initiative

Invitation to Participate and Description of Project:

You are invited to be part of a study of people with childhood disintegrative disorder (CDD), which is characterized by late-onset, severe regressive autism. Little is known about the causes of CDD. Our study aims to better understand CDD by reviewing medical and educational records, analyzing responses from caregiver questionnaires, and analyzing pre- and post-regression home video clips. Furthermore, since there is evidence for a genetic contribution to CDD, we are also collecting saliva or cheek swab samples for DNA extraction and future genetics analysis.

Our study is being done in part to try to find out why some members of your family are affected with these disorders and others are not. Therefore, unaffected members of your family are important to this study. Eventually, we hope that this research will enable us to identify a genetic factor or factors that cause certain individuals to become affected with a particular illness.

You will not be expected to change any of your medications or any other kind of treatment in order to participate in this study.

To decide whether or not you wish to be part of this research study, you should know enough about its risks and benefits to make an informed decision. This consent form gives you detailed information about the research study and a member of the research team will discuss it with you. We will go over all aspects of this research including its purpose and possible benefits and risks. You will then be asked to be part of the project, and if so to sign this form.

You will be given a copy of this consent form to keep.

Description of procedures:

1- We will obtain a saliva or cheek swab sample for genetic analysis.

Your saliva or cheek swab will be used to study your genes and to do analyses to find mutations (variations of genetic information) that might contribute to CDD.

Samples might be used as de-identified, coded control samples for other genetic studies.

We will not tell you about any of the research results because our studies are performed as research. They do not meet the standards of certified genetic testing laboratories, and do not offer any treatment. If you wish to have standard diagnostic testing performed, you can obtain a referral from your primary care provider to a laboratory which conducts clinical genetic testing.

2- We will ask you to tell us about your health history.

a. You may be asked to give us access to some of your medical and educational records (only records that are relevant to this study) by signing a record release form.

b. We will ask you to tell us about your family's health history- especially about behavioral, cognitive and or social impairments and conditions.

c. We will ask you to provide home video clips (only those relevant to the study) and allow these clips to be viewed by the authorized study team at the UC Davis Medical Center.

3- If you have relatives outside of your immediate family with diagnoses on the autism spectrum it would be very helpful if you made them aware of the study and asked them to contact us at [203-479-0219](tel:203-479-0219). If that is not feasible, and if they tell you that it is okay with them, we will contact them and discuss the project. Their willingness to participate does not affect your participation in this project.

4- Interview and questionnaires

We will ask you to complete online questionnaires to collect information about symptoms of cognitive, behavioral, and social impairment.

5- We will ask your permission to submit de-identified clinical and genetic data to the National Database for Autism Research (NDAR and/or similar restricted-access scientific databases). By initialing this item under authorization and permission at the end of this form, submission of data to the restricted-access scientific database can be used by qualified researchers for future studies. All information will be de-identified prior to submission to NDAR. De-identified means that the researchers will use your information without knowing your identity. The genetic data that you have donated for this research study will be sent to NDAR along with the following information about you: age at sample collection, sex, race, and relevant clinical diagnosis and laboratory values.

Risks and Inconveniences:

1- Saliva/cheek swab collection

There are no known risks associated with obtaining a saliva or cheek swab sample.

2- Genetic analysis: There is a federal law called the Genetic Information Nondiscrimination ACT (GINA). In general, this law makes it illegal for health insurance companies, group health plans, and most employers to discriminate against you based on your genetic information. However, it does not protect you against discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. Since the analysis done on your genetic sample is for research only, the risks are minimal.

Every effort is made to minimize these risks including:

- No genetic data or results from this study will be given to you or your physician.
- The results of research testing will not appear in your medical records.
- No individual identifiers [i.e. name, address] will be used for any testing. All samples and data are given a unique code to remove any identifying information.

In the very unlikely case that this research identifies biological relationships within your family, such as issues of paternity that were not previously known, you will not be told.

3- It is possible that you may become tired while filling out questionnaires. You may take breaks as often as you want. Some of the questions may make you uncomfortable or upset. You are free to refuse to answer any questions or to stop at any time. You may speak with the investigators about any concerns and ask any the questions.

4- It is unlikely, but it is possible that this study could determine that you have a previously undiagnosed condition. The results of the research testing will not appear in your standard medical records.

5- Although every effort is made to prevent identification of the subject is made, there is a remote possibility that a subject's identity could be revealed in a video clip. Potentially, this would result in a loss of privacy.

Confidentiality and privacy:

No individual identifiers [i.e. your name, address] will be used in research files. All samples and data are given a unique code to remove any identifying information. This coded data will be kept in locked files accessible only to the research investigators.

Home video clips submitted as research records will also be de-identified, given codes, and stored with other research records in a secured location. Only the research investigators and certain authorized study personnel will have access to these videos.

Data will be maintained in a secured server at Yale School of Medicine. The server is a HIPAA [federal regulations for privacy of patient information] compliant, encrypted computer resource that ensures data integrity through secure collection, storage, and retrieval. There are varying levels of data access for investigators and study team members as appropriate for their portion of the project. Only the Principal Investigators, Dr. Gupta and Dr Fernandez, and select members of the study team will be able to link samples and data to patient identifiers.

No individual identifiers [i.e. your name, address] will be used in any reports or publications resulting from this study.

The Yale University Human Investigation Committee (HIC- the committee that reviews, approves and monitors human subject research) and The Simons Foundation (the sponsor of this study) may review the research data. These agencies are required to keep information confidential.

The information about your health that may be collected in this study includes:

- Past and present medical and educational records relevant to the study
- Past and present home video clips relevant to the study
- Research records
- Questionnaires

It is important for you to know that information about you [collected for this study] that might identify you may be seen by:

- The Simons Foundation and representatives from Yale University and the Human Investigation Committee, who are responsible for insuring research compliance. These individuals are required to keep all information confidential.
- The Principal Investigators, Dr. Abha Gupta and Dr. Thomas Fernandez
- Other study investigators including the researcher responsible for assigning code numbers to samples and data
- The authorized study team at UC Davis Medical Center responsible for coding home videos
- The Study Coordinator who is the liaison between study subjects and the research team
- Those individuals at Yale who are responsible for the financial oversight of research including billings and payments.

All of the organizations and individuals listed above are required to keep information confidential.

The research team can only give information about you to others for research with your permission. U.S. or State law may also require that we give information to others. Examples of

information that we are legally required to disclose include abuse of a child or elderly person, or certain reportable diseases.

The biological specimens (saliva or cheek swab samples) may undergo large-scale DNA sequencing. These studies would help us to understand the disease mechanisms in more detail. The sequencing is purely research-based and not looking for any standard, routine genetic testing. You will not receive any results from these basic-research tests.

At the end of this consent form there is a section for additional future research. You may decline further studies and still participate in the main study. We have anticipated that the samples could be very useful in understanding diseases and developing new therapies and thus provide a major benefit for medical research.

All data relevant to this research will be stored in locked file cabinets or on a secured server at Yale School of Medicine .

By signing this form, you authorize the use and/or disclosure of the information described above for this research study. The purpose for the uses and disclosures you are authorizing is to ensure that the information relating to this research is available to all parties who may need it for research purposes.

All health care providers subject to HIPAA (Health Insurance Portability and Accountability Act) are required to protect the privacy of your information. The research staff at the Yale School of Medicine and Yale New Haven Hospital, and the UC Davis Medical Center are required to comply with HIPAA and to ensure the confidentiality of your information. Some of the individuals or agencies listed above may not be subject to HIPAA and therefore may not be required to provide the same type of confidentiality protection. They could use or disclose your information in ways not mentioned in this form. However, to better protect your health information, agreements are in place with these individuals and/or companies that require that they keep your information confidential.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity unless your specific consent for this activity is obtained.

If in the future, we identify information that we believe is important to your health, we will consult with the Human Investigation Committee overseeing this work to decide the best way to get this information to you and your health care provider.

This research is covered by a Certificate of Confidentiality from the National Institutes of Health. The researchers with this Certificate may not disclose or use information, documents, or biospecimens that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other action, suit, or proceeding, or be used as evidence, for example, if there is a court subpoena, unless you have consented for this use. Information, documents, or biospecimens protected by this Certificate cannot be disclosed to anyone else who is not connected with the research except, if there is a federal,

state, or local law that requires disclosure (such as to report child abuse or communicable diseases but not for federal, state, or local civil, criminal, administrative, legislative, or other proceedings, see below); if you have consented to the disclosure, including for your medical treatment; or if it is used for other scientific research, as allowed by federal regulations protecting research subjects.

The Certificate cannot be used to refuse a request for information from personnel of the United States federal or state government agency sponsoring the project that is needed for auditing or program evaluation by the National Institutes of Health which is funding this project or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it.

The Certificate of Confidentiality will not be used to prevent disclosure for any purpose you have consented to in this informed consent document.

Benefits:

The research conducted in this study is not designed to benefit you directly. However, it is possible that knowledge gained through research will help people in the future by creating treatments and therapies.

Economic Considerations:

There are no charges to you for your participation.

All research tests and visits will be provided at no cost to you. It is important to point out that our studies are performed as research. They do not meet the standards of certified genetic testing laboratories, and do not offer any treatment.

You will not be paid for participating in this study.

In Case of Injury:

Although the risks associated with this study are minor, if you are injured as a direct result of participation, we will provide treatment. You and your insurance will be responsible for the costs of this treatment. Financial compensation for injury is not routinely available.

You do not give up any legal rights by signing this form.

Voluntary Participation and Withdrawal:

You do not have to take part in this study. Refusing to participate will involve no penalty or loss of benefits to which you are otherwise entitled (such as your health care outside the study, the payment for your health care, and your health care benefits). Your health care outside the study

will not change if you do not agree to participate. However, you will not be able to enroll in this research study and will not receive study procedures as a study participant if you do not allow use of your information as part of this study.

Withdrawing from the Study-

If you decide to take part in this study, and then change your mind, you can always stop and withdraw from this study at any time during its course. Withdrawing from the study will involve no penalty or loss of benefits to which you are otherwise entitled. It will not harm your relationship with your own doctors or with Yale-New Haven Hospital. The researchers may also withdraw you from participating in the research if necessary.

To withdraw from the study, you can contact a member of the research team at any time and tell them that you no longer want to take part.

Withdrawing your Authorization to Use and Share your health information-

You may withdraw or take away your permission to use and disclose health information at any time. If permission is withdrawn, you will not be able to stay in this study.

If you do not want researchers to use and disclose your health information as described in the Confidentiality section, you and your parent(s) may withdraw your permission by telling the study staff or by writing to the principal investigators *Abha Gupta or Thomas Fernandez, Yale Child Study Center, 230 South Frontage Road, New Haven, CT 06520, Tel: (203) 479-0219 or (203) 713-3113*. When you do that, no new health information identifying you will be collected after that date. Again, the investigators will be able to use the information that they already collected about you to finish the study.

This authorization to use and disclose your health information will never expire unless and until you change your mind and revoke it.

Questions:

We have used some technical terms in this form. Please feel free to ask about anything you do not understand, and to consider this research and the consent form carefully, for as long as you feel is necessary, before you make a decision.

Options to Choose for Additional Future Research

Under each question, please initial the optional future studies for which you give your consent.

1. For future medical research purposes, we we would like to ask your permission to donate your de-identified clinical and genetic data to NDAR and/or similar restricted-access scientific databases.

----- I agree to donate my de-identified clinical and genetic data to NDAR and/or similar restricted-access scientific databases.

----- I DO NOT allow permission for my de-identified data to be submitted to NDAR and/or similar restricted-access scientific databases.

2. The study investigators may be interested in re-contacting families who participate in this study for future research. Some possible reasons for this include: if the study investigators wish to extend the study to additional family members who were not initially included or wish to re-test individuals at a later date so as to chart their development over time. If you agree to be contacted in the future, you could still decide at that time not to participate in any such additional activities.

----- I agree to be contacted by the investigators for future research studies.

----- I DO NOT agree to be contacted by the investigators for future research studies.

Authorization and Permission:

I have read (or someone has read to me) this form and have decided to participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

By signing this form, I give permission to the researchers to use [and give out] information about me for the purposes described in this form. By refusing to give permission, I understand that I will not be able to be in this research.

Name of Subject: _____

Signature: _____

Signature of Principal Investigator
Or

Date

Signature of Person Obtaining Consent

Date

If you have further questions about this project, or if you have a research-related problem, you may contact the principal investigators, Abha Gupta, MD, PhD at (203) 479-0219 or Thomas Fernandez, MD, at (203) 713-3113. If you have any questions concerning your rights as a research subject, you may contact the Human Investigation Committee at (203) 785-4688. If after you have signed this form you have any questions about your rights, please contact the Yale Privacy Officer at 203/436-3650.