Genomic testing
patient consent form

Details of patient being tested:	
First name	
Surname	
Date of birth	
URN	

Parent/guardian/other representative (if applicable):	
First name	
Surname	
Date of birth	
Relationship	

It is my choice for the above-named patient to have genomic testing by panel/exome/genome analysis to look for changes in genes that may be associated with:

_____

1. About the test

I understand:

- This test does not detect all genetic changes or predict all possible health conditions.
- Genomic test results are based on current knowledge which may change in the future.
- The sample or results may be re-examined in the future using new knowledge or testing methods.

2. Potential outcomes

I understand:

- This test may or may not find a cause for the condition(s).
- This test may find a genetic change of 'uncertain significance', which means it cannot be understood today.
- The test may find a genetic change not related to the reason for testing (incidental findings).
- The test may show unexpected family relationships.
- More tests or analysis may be needed to understand the results. This may include testing blood relatives.

3. Results

I understand:

- I can choose not to be told about the results, but the report may still be included in the medical record.
- Results may affect the ability to obtain some types of insurance.
- Results may have health implications for blood relatives.
- Results are confidential and may be released as specified in this form, or as allowed by law.

I give permission for the report to be shared with health professionals involved with the care of:

☐ all relatives of the patient ☐ specific relatives: _____

The following individual can be given the results, if I am unable to be contacted:

Name: _____ Contact number: _____

4. Data and sample sharing

I understand and agree that the sample, genomic data and related health information may be shared with genomic and medical databases used for patient care. All identifying information will be removed.

5. Research (optional)

I consent to share the sample, genetic test data and related health information for ethically approved research. I understand identifying information will usually be replaced with a unique code so that information can be returned to me in some situations. I understand that if I no longer want to be involved in research, I can contact my health professional to discuss my withdrawal.

☐ Yes ☐ No

6. Patient/parent/guardian declaration

I have had enough time to consider the information in this consent form and:

- I understand the reason for testing and the potential benefits, consequences and limitations.
- I have been able to discuss the information with a health professional, ask questions and have any concerns addressed.
- I am satisfied with the explanations and answers to my questions.
- I have been offered a copy of this consent form.

I provide consent for genomic testing as summarised in this form.

Patient/parent/guardian signature: _____ Date:_____

7. Health professional declaration

I, (health professional name) _____ have provided information on the reason for and nature of the test, possible results, limitations and material risks of the test. The patient has been able to ask questions and consider the answers before completing this form

Signature: _____ Date: _____

Consent for biological parents* undergoing duo/trio analysis (complete if applicable)

By signing below, we consent to genomic testing as described in this form for the purpose of assisting in the interpretation of the genomic results of our child (the patient named above).

I consent to genomic testing for the purpose of assisting in the interpretation of the genomic results of the patient named above. I understand the reason for testing and the potential benefits, consequences and limitations. Specifically, I understand that the details of genomic testing outlined above apply to my sample, results and related information. I have been able to discuss the information with a health professional, ask questions and have any concerns addressed. I am satisfied with the explanations and answers to my questions.

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Name:		
Date of birth:		
Signature:		

**If both parents cannot sign one form, duplicate this form and ask each parent to sign a separate copy and submit both to the lab.*

Parent research consent (optional):

I consent to share my sample, genetic test data and related health information for ethically approved research. I understand identifying information will usually be replaced with a unique code so that information can be returned to me in some situations. I understand that if I no longer want to be involved in research, I can contact my health professional to discuss my withdrawal.

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Consent for research:	☐ No ☐ Yes	☐ No ☐ Yes