

[Service logo and details]

**PATIENT DETAILS**

[patient label]

**First name(s):**

**Surname:**

**Date of birth:**

**Sex:**

**UR:**

## Clinical Genetic Testing Consent Form

**Genetic test:** ☐ Single gene ☐ Single variant ☐ Multiple variants ☐ Other (specify) \_\_\_\_\_

**Clinical indications or condition tested for:** \_\_\_\_\_

**Test purpose:** ☐ Diagnostic test ☐ Predictive test ☐ Carrier test ☐ Prenatal test ☐ Confirmation test  
☐ Segregation analysis ☐ Other (specify) \_\_\_\_\_

**It is my choice to have genetic testing. I understand that:**

1. The test does not detect all genetic changes or predict all possible health conditions.
2. The test may find a genetic change of uncertain significance.
3. More tests or analysis may be needed to understand the results. This may include testing blood relatives.
4. The sample or results may be re-examined in the future using new knowledge or testing methods.
5. Results may have health implications for blood relatives.
6. Results may show unexpected family relationships.
7. Results may affect the ability to obtain some types of insurance.
8. The sample will be stored and may be shared with other laboratories to assist with genetic testing.
9. Results and related health information may be shared with genetic and medical databases that are used for patient care. All identifying information will be removed.
10. Results are confidential and will only be shared with my consent, or as required or permitted by law.
11. I can change my mind about testing and choose not to be told the results, but if testing has started, a report will remain in medical records

**The following person can be given the results if I cannot be contacted, including in the event of death:**

NAME

CONTACT DETAILS (EMAIL AND PHONE NUMBER)

- I consent to share the results and related information with health professionals to help with the genetic testing of blood relatives. I understand that identifying information will not be disclosed to the relative wherever possible.  
☐ Yes ☐ No
- I consent to my test results being uploaded to MyHR. ☐ Yes ☐ No

**Optional (based on jurisdictional policy/procedural requirements):**

- I consent to share the sample, genetic test data, and related health information for ethically approved research into the same or related conditions. I understand identifying information will be removed and 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

**Patient/Proxy Declaration:**

- I consent to genetic testing.
- 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.

NAME OF PATIENT

SIGNATURE

DATE

**Or, where consent is given on behalf of another:**

NAME OF PROXY

SIGNATURE

DATE

PROXY'S RELATIONSHIP TO PATIENT

CONTACT DETAILS (EMAIL AND PHONE NUMBER)

**Health Professional Declaration:**

I, \_\_\_\_\_  
NAME OF HEALTH PROFESSIONAL

SIGNATURE

DATE

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.

Optional (based on jurisdictional policy/procedural requirements):

Interpreter/Liaison Officer: ☐ Not Applicable

I, 

NAME OF INTERPRETER/LIAISON OFFICER

SIGNATURE

/

/

DATE

have interpreted the content of this form and all the information supplied by the health professional to the patient.