[Service logo and details]

**PATIENT DETAILS** [patient label]
**First name(s):**
**Surname:**
**Date of birth:**
**Sex:**
**UR:**

# Clinical Tissue-targeted (Somatic) Genomic Testing Consent Form

**Clinical indications or condition tested for:**

**Test purpose:** This test can be used to assist with diagnosis and may help inform treatment options and prognosis.

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**It is my choice to have tissue-targeted genomic testing. I understand that:**

1. This test aims to look for genetic changes in the tissue sample that may be related to the condition.
2. The test does not detect all genetic changes or all genetic conditions.
3. Although not intended, this test may find a result that is unrelated to the current condition and/or could have implications for blood relatives.
4. To better understand the test results, more testing, a new tissue sample or further review of the current sample may be needed.
5. As part of patient care, results and related health information may be shared with clinical databases. All identifying information will be removed.
6. Results are confidential and will only be shared with my consent, or as required or permitted by law.
7. 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 patient medical records and/or My Health Record.

**If I cannot be contacted, the following person can be given the results, and I will discuss this with them (optional):**

*NAME* *CONTACT DETAILS (EMAIL AND PHONE NUMBER)*

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**Additional consent**

8. If a genetic change is found that may be relevant to blood relative/s, I consent that test results and related information can be shared with health professionals to help with the genetic testing of relative/s. I understand that identifying information will not be shared with relative/s wherever possible. □ Yes □ No

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

- Test results may be uploaded to My Health Record (MyHR). □ Yes □ No



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**Patient/Proxy Declaration**

- I consent to tissue-targeted (somatic) genomic 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 (i.e. parent or guardian):**

| | | |
|---|---|---|
| | | ___/___/___ |
| *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.



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