CONSENT FOR GENETIC TESTING is provided by (please tick an option below):

☐ An adult (a patient with capacity)

☐ A mature minor (a patient with capacity)

I (the health practitioner) have assessed this patient to be a minor with capacity to give consent as they have demonstrated sufficient maturity and intellect to fully understand what is proposed.

☐ A parent / guardian of a minor without capacity

PROVISION OF INFORMATION TO PATIENT / PARENT / GUARDIAN

To be completed by Health Practitioner

I __________________________________________________________________________________________________________________

INSERT NAME OF HEALTH PRACTITIONER

have discussed with this patient/ parent/ guardian the reason for conducting the proposed genetic test*. I have informed this patient/ parent/ guardian of the nature, possible results, limitations and material risks of the proposed genetic test*, as confirmed on this form by this patient/ parent/ guardian.

This patient/ parent/ guardian has been offered additional written information and/or reference to online resources about the genetic testing.

Genetic testing is being conducted for ________________________________________________________________________________

___________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________

INSERT NAME OF CONDITION(S) OR CLINICAL INDICATIONS

*TYPE OF GENETIC TEST (please tick an option below):

☐ Carrier Testing: a genetic test performed on a person to identify if they carry a gene change.

☐ Diagnostic Testing: a genetic test performed on a person to identify a specific genetic condition.

☐ Predictive/Presymptomatic Testing: a genetic test performed on a person with a family history of a genetic condition, who does not usually have symptoms at the time of testing, to determine if they have inherited that condition or susceptibility to that condition.

☐ Prenatal Testing: a genetic test to identify possible genetic conditions in an unborn baby.

☐ Other (please specify): ____________________________________________________________

___________________________________________________________________________________________________________________

INTERPRETER PRESENT ☐ Yes ☐ No

INSERT NAME OF INTERPRETER ____________________________ SIGNATURE ____________________________

______ / _______ / _______ : _______ AM/PM

DATE TIME EMPLOYEE ID / PROVIDER NUMBER

SIGNATURE OF HEALTH PRACTITIONER ____________________________ _______ / _______ / _______
To be completed by Patient / Parent / Guardian

I understand and acknowledge that:
✓ A blood, saliva or tissue sample will be used to test DNA;
✓ I will be told the results by a health practitioner;
✓ This is not a “general health test”;
✓ Results are based on current knowledge that may change in the future;
✓ This test will not predict all future health problems;
✓ I can change my mind about having the test performed or about receiving genetic test results at any time by contacting the health practitioner;
✓ There are a number of different possible results from the testing and these can have implications for me/my child and my/my child’s family;
✓ The results may be of “unknown or uncertain significance”, which means they cannot be understood based on current knowledge;
✓ There is a chance that some genetic tests could identify other medical conditions (or susceptibility to other medical conditions) as an incidental finding;
✓ The genetic test results may identify unexpected family relationships;
✓ The genetic test results may affect my/my child’s ability to obtain some types of insurance (for example, life insurance);
✓ Further testing may be needed to finalise the result;
✓ The reason for testing and the potential benefits, consequences and limitations involved in the testing have been explained in a way I understand;
✓ I have had an opportunity to discuss the information, ask questions and have any concerns addressed and I am satisfied with the explanations and answers to my questions;
✓ My/my child’s results are confidential and will only be released with my consent or as required or permitted by law.

RELEASE OF GENETIC TESTING RESULTS (please tick YES or NO)

► My/my child’s test results can be shared with relevant health practitioners involved in the care of my/my child’s family members (genetic relatives):
  Genetic relatives are people who are related to an individual by blood, for example, a sibling, parent or descendant of the individual.
  Please note: Genetic information can be used and disclosed without consent in order to lessen or prevent a serious risk to the life, health or safety of a genetic relative no further removed than third degree; and, only where the disclosure is made in accordance with the guidelines issued by the Information and Privacy Commission NSW.

► If I cannot be contacted, details of my/my child’s test results can be released to a nominated individual:

Please provide contact details for an appropriate person:
Name: ___________________________, Phone: ___________________________
Relationship to Patient: ______________________________________________________

ADULT AND MATURE MINOR CONSENT (a patient with capacity)

I consent to genetic testing as discussed with _____________________________

INSERT NAME OF HEALTH PRACTITIONER

________________________/________/________

SIGNATURE OF PATIENT

DATE

PARENT/GUARDIAN CONSENT (a parent / guardian of a minor without capacity)

I consent to genetic testing as discussed with _____________________________

INSERT NAME OF HEALTH PRACTITIONER

________________________/________/________

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO MINOR OF PARENT/GUARDIAN

ADDRESS