NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSENT: GENETIC TESTING

(for all types of genetic and genomic testing for ADULTS, MATURE MINORS and MINORS)

SMR020115

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 — DATE

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH700574 201119

CONSENT: GENETIC TESTING (for all types of genetic and genomic testing for ADULTS, MATURE MINORS and MINORS)

SMR020.115

NO WRITING

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CONSENT: GENETIC TESTING

(for all types of genetic and genomic testing for ADULTS, MATURE MINORS and MINORS)

PATIENT / PARENT / GUARDIAN CONSENT

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): ☐ Yes ☐ No

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: ☐ Yes ☐ No

Please provide contact details for an appropriate person:

Name: _____ Phone: _____

Aug 1

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

_____ _____ _____ / _____ / _____
INSERT NAME OF PATIENT 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

for _____
INSERT NAME OF MINOR

_____ _____ _____/ _____ / _____
INSERT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
RELATIONSHIP TO MINOR OF PARENT/GUARDIAN ADDRESS

NO WRITING