		FAMILY NAME		MRN				
		GIVEN NAME						
		D.O.B//	M.O.					
		ADDRESS	ADDRESS					
	CONSENT:							
	GENETIC TESTING (for all types of genetic and genomic testing	LOCATION / WARD	LOCATION / WARD					
	ADULTS, MATURE MINORS and MINORS		AILS OR AFFIX	PATIENT LABEL HERE				
115	CONSENT FOR GENETIC TESTING is provided by (please tick an option below):							
SMR02011	An adult (a patient with capacity)							
SMF	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							
		-	To bo compl	otod by Hoalth Practitionar				
	PROVISION OF INFORMATION TO PATIENT / PARENT / GUARDIAN To be completed by Health Practitioner							
	INSE	ERT NAME OF HEALTH PRACTITIONER						
	have discussed with this patient/ parent/ quardian	have discussed with this nationt/naront/quardian the reason for conducting the proposed constitutests. I have informed						
G	have discussed with <i>this patient/ parent/ guardian</i> the reason for conducting the proposed genetic test*. I have informed <i>this patient/ parent/ guardian</i> of the nature, possible results, limitations and material risks of the proposed genetic test*, as							
NO WRITIN	confirmed on this form by this <i>patient/ parent/ guardian</i> . This patient/ parent/ guardian has been offered additional written information and/or reference to online resources about the							
WR	genetic testing.							
ON -	Genetic testing is being conducted for							
RGIN								
MAR(
	INSERT NAME	OF CONDITION(S) OR CLINICAL INDICA	TIONS					
BINDING								
B	*TYPE OF GENETIC TEST (please tick an optic	on below):						
	Carrier Testing: a genetic test performed on a	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.	no or tooting, to determine in they	nave inferited t					
	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	EMF	PLOYEE ID / PROVI	DER NUMBER				
201119								
			/	1				
NH700574	SIGNATURE OF HEALTH PRAC	TITIONER	/	DATE /				
~								

Image:	-1221-	FAMILY NAME		MRN						
Facility: DOB	NSW Health	GIVEN NAME			EMALE					
Appress CONSENT: GENETIC TESTING Up all types of genetic and genomic testing for ADULTS MUTCRE MINORS and MINORSSI Description of the second set of the second sec		D.O.B//	M.O.							
<form></form>		ADDRESS								
(for all types of genetic and genomic testing for DURLS MATURE MINORS and MINORS) COMPLETAL DETAILS OR AFFIX PATIENT LABEL HERE DURLS MATURE MINORS and MINORS) Completed by Patient / Parent / Guardian Indentify and acknowledge that: A blood, saliva or tissue agained will be used to test DNA; A blood, saliva or tissue agained will be used to test DNA; Indentify a general health thet?: I can bange my mind about having the test performed or about receiving genetic test results at any time by contacting the health practitioner; The results may be of 'unknown or uncertain significance', which means they cannot be understood based on current knowledge; There are a number of difforent possible results from the testing and these can have implications for <i>melmy child</i> and <i>my' my child</i> family: There are the structure may test of 'unknown or uncertain significance', which means they cannot be understood based on current knowledge; There are test results may identify unexpected family relationships; The results results may be of unknown or uncertain significance', which means they concerns addressed and I am satisfied undifficant to be abard with relevant health practitioners involved in the testing have been esplained in a way Understand; The results tresults are obtained with relevant health practitioners involved in the care or my child's test results can be shared with relevant health practitioners involved in the care or my child's test results. Complexity be released to a mindividual by bood, for example, as thing, parent or descendand the mad with a genene insplexe to the thealth machin the degree										
ADULTS. MATURE MINORS and MINORS) COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE PATIENT / PARENT / GUARDIAN CONSENT To be completed by Patient / Parent / Guardian Understand and acknowledge that: A blood, salw or tissue sample will be used to test DNA; 1 will be told the results by a health practitione:		LOCATION / WARD								
Understand and acknowledge that: Midle to due and the processing of the sends to proceed the processing of the results by a valid by processing of the future. I will be tool the results by a valid by processing of the future. File is not a "general health test": File is not a "general health test: file is number of different possible results from the testing and these can have implications for <i>memy child</i> and <i>my' my child</i> is a chance that some genetic tests could identify other medical conditions (or susceptibility to other medical conditions) as an incidental finding: Chare head a charest test results may affect <i>my/my child</i> 's ability to obtain some types of insurance (for example, life insurance): I The results are conditatial and will not be relaxed with my consent or as required or permitted by law: <i>My/my child's</i> test results are obtained and answers to <i>my questions Genetic relaxies ang epiciple who are related to an individual by blood, for example, a s</i>										
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; This test will not predict all future health problems; This test will not predict all future health problems; This test will not predict all future health problems; This test will not predict all future health problems; This test will not predict all future health problems; This test will not predict all future health problems; This test will not predict all future health problems; There are a number of different possible results from the testing and these can have implications for <i>me/my child</i> and <i>my/my child</i> stamily; The results may be of "unknown or uncertain significance", which means they cannot be understood based on current knowledge; and indextal funding; The genetic test result may difect <i>my/my child</i> sability to obtain some types of insurance (for example, life insurance); Further testing may be needed to finalise the result; The results for testing and the potential benefits, consequences and limitations involved in the testing have been explaned in a way I understand; 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; Genetic relatives and postpatient to discuss the information, ask questions and have any concerns addressed and I am satisfied with the explanations and answers to my questions; Genetic relatives and postpatient to discuss the information, ask questions and have any concerns addressed and I is assisted or or information and with relevant health practitioners involved in the care or testing and the formation and Privacy Commission NSW. If all cannot be contacted, defaults of <i>my/my child</i> steptizents can be released to a nominated individual: Yes No O Please provide contact details for an appropriate person: Name:	PATIENT / PARENT / GUARDIAN CONSENT To be completed by Patient / Parent / Guardian									
My/my child's results are confidential and will only be released with my consent or as required or permitted by law. RELASE 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 Yes No My/my child's test results can be shared with relevant health practitioners involved in the care 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 and be used and disclosed without consent in order to lessen or prevent a serious risk to the life, health or safety of a genetic relatives or moved than third degree; and, only where the disclosure is made in accordance with the guidelines sisted by the Information and Privacy Commission NSW. If I cannot be contacted, details for an appropriate person: Name:	 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 <i>me/my child</i> and <i>my/my child</i>'s family; ✓ There 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 identify unexpected family relationships; ✓ 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 									
	 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 Yes No 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 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 									
ADULT AND MATURE MINOR CONSENT (a patient with capacity) I consent to genetic testing as discussed with	Name:	Name: Phone:								
for INSERT NAME OF MINOR / /	ADULT AND MATURE MINOR CONSENT (a patien	t with capacity)			Ø					
for INSERT NAME OF MINOR / /	INSERT NAME OF PATIENT		т —	///	§ R					
for INSERT NAME OF MINOR / /										
INSERT NAME OF MINOR		INSERT NAME OF HEALTH	PRACTITIONE	R	115					
	for INSERT NAME OF MINOR									
RELATIONSHIP TO MINOR OF PARENT/GUARDIAN ADDRESS	INSERT NAME OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GU	ARDIAN	///						
	RELATIONSHIP TO MINOR OF PARENT/GUARDIAN	ADD	RESS							

NO WRITING