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Department of Molecular Genetics

Australian Renal Gene Panels by Massively Parallel Sequencing (MPS) request form

Please read the MPS renal panel information sheet before using this request form

Patient details

MRN: DOB: Sex: Male Female

Surname: First name:

Patient address:

Postcode:

Specimen type: Blood or DNA

Tissue:
(if not blood)

If DNA, source of DNA:

Requesting doctor

Name:

Provider number:

Email:

Phone:

Address:

Signature:

Nephrologist &/or Clinical Geneticist

Name:

Provider number:

Email:

Address:

Billing details - Please send invoice to (Please note that MPS has no Medicare item number)

Name: Address:	Authorisation to invoice institution/patient obtained:

Genetic testing consent

Copy of MPS genetic testing consent attached: Original to be stored with patient's medical record. Testing will not be started unless a copy is sent to the laboratory.	

MPS Renal panel request form - Version: 1.1. Index: SGD-T-F023. Printed: 16-Jun-2015 12:22

Panel Requested

☐ Initial testing	☐ Re-analysis of MPS data
☐ Atypical Hemolytic Uremic Syndrome (aHUS) panel	☐ Hyperoxaluria panel
☐ Alport syndrome panel	☐ Cystinosis (by Sanger sequencing)
☐ Nephrotic syndrome panel	
☐ Other, please list genes required:	

Clinical indications for referral – Please provide a clinical summary of the patient. If insufficient details are provided, testing may not proceed without consultation with the referring clinician.

Suspected diagnosis:	Family history:
Renal, renal imaging and renal biopsy findings	
Deafness:	Ocular system features:
Cardiovascular system features:	Pulmonary system features:
Skeletal system features:	Neurological (incl. neuromuscular) features:
Dysmorphism:	Other features:
Skin & integument features:	Haematological features:

Previous testing or Comments

☐ Array performed. Lab:	Result:
☐ Array requested. Lab:	
Comments:	

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Consent Form for Massively Parallel Sequencing Testing

Genetic File:	MRN:

Parent or Guardian
(Patient under age or unable to consent)

Surname:	Given names:
Address:	
	Postcode:
Date of birth:	Telephone:

Patient

Surname:	Given names:
Address:	
	Postcode:
Date of birth:	Telephone:

Part A: Provision of Information to Patient

To be completed by Health Professional

Testing requested:

☐ **Panel of genes known to cause** _____

☐ **Whole exome/whole genome testing**

Possible outcomes of genetic testing:

1. An **informative** result means that a variant has been found and that it explains the clinical findings.
2. If a variant is not found, the result is **uninformative**. This may be because a variant is present but could not be found using current technology. An uninformative result **does not** exclude the diagnosis.
3. Results of **uncertain significance**: sometimes a variation in a gene is found but its meaning is unclear. In this situation, further testing of other family members may be required. The interpretation of a result may also alter as knowledge of genetics improves. I may be contacted if this occurs but the time frame for any additional results is variable.
4. There is a small chance that co-incidental findings about my/my child's health not related to the diagnosis in me/my child may be identified when genomic testing is carried out. I will be informed of these co-incidental findings only if an expert committee, in consultation with my doctor or genetic counsellor, assess that these findings could have a significant impact on my/my child's/my relatives' health care.
5. Testing may reveal non-paternity or non-maternity of a presumed natural parent
6. Testing may possibly affect my/my child's ability to obtain some types of insurance.
7. Relevant clinical testing results will be given in person.
8. The information from genetic testing will be stored by the laboratory according to government regulations.
9. Sample collected (blood/muscle/skin/_____) may be stored for an indefinite time and can be retested if future testing may be more informative.

I, _____ have informed this patient/parent/guardian
Insert name of Health Professional and designation

as detailed above, of the nature, limitations, likely results and risks associated with the testing of genes. We

MPS Testing Consent Form - Version: 1.1. Index: SGD-T-F020. Printed: 03-Jun-2015 12:56

have discussed the procedures and consequences of testing and storage of the patient's sample.

Signature of Health Professional	Signature of Interpreter (if present)	Date

Part B: Patient Consent

To be completed by Patient/Guardian

1. I consent to testing a panel of genes known to cause _____ and/or whole exome/genome sequencing as requested by my healthcare provider.

   ☐ **YES, I consent to genetic testing.** ☐ **NO, I do not consent to genetic testing.**

2. I agree that the result may also be used, if necessary, to help other family members, for their counseling and diagnosis, without disclosing specific details about the person tested.

   ☐ **YES, I consent to results being made known if reasonably indicated to other family members**

   ☐ **NO, I request that results only be made known to the following people** _____

   In the event of my death, the test results should be released to:

   Name: _____ Relationship: _____

   Contact details: _____

3. I agree that my de-identified genetic data may be submitted to genome-wide depositories as part of a global effort to better understand the role of gene variations in disease and health.

   ☐ **YES, my de-identified may be submitted to genome-wide depositories.**

   ☐ **NO, my de-identified may not be submitted to genome-wide depositories.**

4. After testing is completed, there may be research studies that I/my child may be eligible for and may be of interest. The laboratory may share my contact information with researchers who have a research study with appropriate ethics approval and for which I/my child may be eligible for participation.

   ☐ **YES, the laboratory may share my contact information if deemed appropriate.**

   ☐ **NO, the laboratory may not share my contact information for any research projects.**

I request and consent to the test described above.

I have read the consent information and understand the potential benefits, limitations and consequences involved in the testing. I have had the opportunity to ask additional questions and I am satisfied with the explanations and the answers provided. I understand that genetic counselling will be available for myself and my family.

Signature of Patient/Guardian	Print name	Date