Clinical Consent Form for Genomic Testing

Patient details. (Please print or attach Patient ID Label.)

Patient Surname:_____ Patient First Name:_____

UR Prefix:_____ UR No.:_____ Hospital:_____

Date of Birth: _____/_____/_____ (dd/mm/yyyy) Gender:_____ (M/F/I)

It is my choice to have genomic testing.

I, _____ (*patient name*) understand that my DNA will be tested by panel/exome/genome to look for changes in genes that may be associated with:

_____ (*condition or clinical indication*)

About the Test

- Genomic test results are based on current knowledge, which may change in the future.
- If I change my mind, I can choose not to be told about the result.

Potential Outcomes

- This test might find a cause for the condition(s).
- This test might not find a cause for the condition(s).
- The result might be of '*unknown significance'*, which means it cannot be understood today.
- There is a chance that genomic testing could find other medical conditions (incidental findings).
- Genomic testing may show unexpected family relationships.
- Further tests or information sharing may be needed to finalise the result.

Results

- I will be told the results by a health professional.
- Results may have implications for the health/genetic risks of my family members.
- I consent to share the results with health professionals to help with the genetic testing of blood relatives. I understand that identifying information will not be disclosed to the relative wherever possible.

  ☐ Yes ☐ No

- Results from these tests may affect my ability to obtain some types of insurance.
- The results will be available to health professionals involved in my care.
- Results are confidential and may not be released without my consent, unless allowed by law.
- The following individual can be given my results, if I am unable to be contacted:

Name _____ **Contact Number:** _____

Data and Sample Sharing
My **de-identified** sample, genomic data and related health information may be shared and stored to help advance scientific knowledge. Information cannot be returned to me. There will not be a direct benefit to me or my family.

Research
I provide consent to share my sample, genomic data and related health information for ethically-approved research into the same or a related condition, where it remains possible to re-identify me. This allows information to be returned to me where appropriate. There may not be a direct benefit to me or my family.

☐ **Yes** ☐ **No**

I have had enough time to consider the information in this consent form and have:

- Had the opportunity to discuss genomic testing and its implications with a health professional
- Been given access to information about genomic testing.
- Been able to ask questions until I am satisfied with the answers.
- Been offered a copy of this consent form.

I provide consent to have genomic testing as summarised in this form.

Signature_____

Date _____

Print Name_____

Date of Birth_____

Email/ Address_____

Health Professional Signature _____Date _____

Health Professional Print Name_____

Adapted from the Clinical Genomic Testing Consent Form V17 05/08/2019.
Developed by Australian Genomics Health Alliance.