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

DO NOT PRINT

***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

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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

NSW GOVERNMENT Health

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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)

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.

DO NOT PRINT

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: _____

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

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BINDING MARGIN - NO WRITING

SMR020115