

Clinical Genomic Testing Consent Form

(Insert Patient Information)

Genomic testing by single gene gene panel exome genome other (specify) _____
is being done for _____

INSERT NAME OF CONDITION(S) OR CLINICAL INDICATIONS

- Diagnostic Testing** is a test to identify the specific gene changes responsible for a person's symptoms.
- Predictive Testing** is a test to identify gene changes in a person at risk of a genetic condition, who does not yet have symptoms.
- Carrier Testing** is a test to identify gene changes that may not affect that person but may affect the health of their future children.
- Prenatal Testing** is a test during pregnancy to identify gene changes that may affect the health of the developing fetus.
- Other** (please specify e.g. segregation testing, cancer/tumour testing, pharmacogenomics): _____

It is my choice to have genomic testing. I understand that:

- ✓ The sample will be used for genomic testing
- ✓ I will be told the results by a health professional
- ✓ This test will not predict all possible health problems
- ✓ Results are based on current knowledge that may change in the future
- ✓ Results may or may not find a cause for the symptoms or may be of uncertain significance
- ✓ The test may show additional findings not related to the reason for testing
- ✓ To better understand the results, more testing or re-analysis may be needed. This may include testing of genetic relatives
- ✓ Results may have health implications for the person being tested and their family
- ✓ Results are confidential and will only be shared with consent or as required or permitted by law
- ✓ If test results are shared with health care providers caring for genetic relatives, efforts will be made not to disclose the identity of the person tested
- ✓ Results may show unexpected family relationships
- ✓ Results may affect the ability to obtain some types of insurance
- ✓ I may be contacted in the future about participation in ethically approved research studies. I may decline any such request.

Patient Declaration

I, _____, _____, _____, _____
INSERT NAME OF PATIENT SIGNATURE DATE TIME

consent to genomic testing as discussed with a health professional. I understand the reason for testing and the potential benefits, consequences and limitations as explained to me. I have had an opportunity to discuss the information I have received, ask questions and have any concerns addressed and I am satisfied with the explanations and answers to my questions.

Health Professional Declaration

I, _____, _____, _____, _____
INSERT NAME OF HEALTH PROFESSIONAL SIGNATURE DATE TIME

have discussed with this patient the reason for conducting the proposed genomic test. I have informed them of the nature, possible results, limitations and material risks of the proposed genomic test, as confirmed on this form by them. This patient has been offered information and/or reference to resources about the genomic testing.

(Optional) Interpreter/Liaison Officer

Yes Not Applicable

I, _____, _____, _____, _____
INSERT NAME OF INTERPRETER/LIAISON OFFICER SIGNATURE DATE TIME

have interpreted the content of this form and all the information supplied by the health professional to the patient.