Informed Consent

SA PATHOLOGY

Genetic testing

Clinical Enquiries: generequest@health.sa.gov.au or 8222 3446 *(doctors may submit completed forms by email from a secure network)*

I/my child/next of kin _____ *(name)* consent to

genetic testing for _____ *(name of condition)*

Clinical indication(s) _____

Gene/Panel/Test name *(if known)* _____

I understand that:

- Genetic testing requires a sample: blood/saliva or tissue, from which DNA will be isolated.
- The laboratory will not analyse genetic changes not known to be associated with the condition(s) above.
- Current methods may not be able to find all genetic changes associated with the condition(s). Not finding a genetic change does not necessarily rule out the condition(s).
- There is a small chance that the test will not work properly or an error will occur.
- Test results may reveal unexpected health risks and/or information on parentage.
- Test results may have implications for children and/or other family members.
- Results from these tests may affect my ability to obtain some types of insurance.
- Genetic test results will be reported only through a doctor or genetic counsellor.
- Results are confidential and may only be released to family members or authorities with consent or as allowed by law.
- Genetic test results are based on best evidence at the time of reporting. SA Pathology does not undertake to perform additional analysis of genetic data after the report is issued.
- Sample(s), including extracted DNA, will be kept for the period required by laboratory guidelines.
- Through a treating doctor, this request may be cancelled or changed before a report is issued.
- With consent (below), sample(s), test results and other relevant information may be used for research studies that have been approved by an Institutional Ethics Committee. Results will not be affected by this choice.

Results are reported as:

- A genetic change associated with the condition *was detected*.
- Analysis *did not detect* any genetic change known to be associated with the condition.
- Genetic changes of *unknown significance* were found*.

*A genetic change is classified as of unknown significance if there is not enough data at this time to allow interpretation. The significance of the result could change in the future as more information becomes available. Genetic changes of unknown significance will only be reported if requested.

I do want to know about changes of *unknown significance**	☐ Yes	☐ No	*(please tick)*
I consent to the use of my sample(s) for *research*	☐ Yes	☐ No	*(please tick)*
I consent to the use of my results for other *family members*	☐ Yes	☐ No	*(please tick)*

Medical Practitioner / Genetic Counsellor Statement

I have explained the potential clinical utility (including risks, benefits and alternatives) of the requested genetic test to this person and answered his/her questions.

Name *(Print)*_____ Signature _____ Date ____/____/____

Patient Statement

My signature below acknowledges that I consent to the genetic testing described above.

Patient Name *(Print)*_____ Patient Date of Birth ____/____/____

Patient signature *(or Guardian/Next of Kin)* _____ Date signed ____/____/____

If parent, Guardian or Next of Kin *(Full Name)* _____ Relationship _____

To ensure privacy, this completed form should only be submitted by your doctor or with your blood sample.

For more information on genetic testing see *www.eshg.org/fileadmin/eshg/documents/ESHG_Patient_leaflet_on_NGS.pdf*

www.sapathology.sa.gov.au

For our patients and our population