Pathology Queensland

CONSENT FOR MOLECULAR DNA TESTING

The following information has been provided to me about Molecular DNA testing:

1. The testing is completely voluntary, and I can withdraw at any stage by contacting my doctor who requested this test.

2. The test will involve the collection of blood / other tissue / __________________________ (please circle / list)

3. The sample will be used for analysis of: __________________________ (gene(s) / genetic disease)

4. A de-identified portion of the sample may be stored in the laboratory for use as a control.

5. The test may not reveal all possible mutations in the genes tested, and mutations in other unknown genes may be responsible for the inherited condition in my family.

6. The test result may have implications for other members of my family and some test results are conditional on the family relationships being as stated.

7. The result will be held by this centre and will be known to clinical staff, the testing laboratory and health professionals involved in my care. The result will only be disclosed to third parties with my consent or if the centre is legally compelled to disclose the result.

8. The sample remains the property of the laboratory. The details of the disease-causing mutation and a de-identified DNA sample may be made available to other laboratories for testing family members. The sample may be stored but its viability for future use cannot be guaranteed.

9. I agree to the retaining or storing of the genomic data and related health information in hard copy or digitally. I am signing this Consent Form of my own free will, on the full understanding and comprehension of the terms of this Consent Form.

A doctor / health professional has explained to me the potential benefits and adverse consequences of the test. I have had an opportunity to ask questions and I am satisfied with the explanations provided.

10. I now CONSENT to the Molecular DNA test and AGREE to the following:
    The results of this test may be used for the healthcare of persons genetically related to me:
    ☐ Yes ☐ No

    Further clinical and/or research genetic testing relating to the condition in me/persons genetically related to me may be performed on my stored DNA sample in the future, including after my death, regardless of whether those persons are known to me or have yet to be born:
    ☐ Yes ☐ No

11. In the event of my death, the test results may be made known to:
    Name: __________________________ Telephone: __________________________
    Signature of patient/guardian: __________________________ Date: _____ / _____ / ______
    Witness: __________________________ Date: _____ / _____ / ______
    Clinician name: __________________________ Signature: __________________________
    Designation: __________________________ Date: _____ / _____ / ______