Queensland Government

CLINICAL GENETIC / GENOMIC TESTING CONSENT

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Test details

Genetic test:

☐ Single gene ☐ Single variant ☐ Multiple variants

☐ Other (specify): .....

Test purpose:

☐ Diagnostic test ☐ Predictive test ☐ Carrier test

☐ Confirmation test ☐ Segregation test ☐ Prenatal test

☐ Other (specify): .....

Genomic test:

☐ Gene panel ☐ Exome ☐ Genome

☐ Other (specify): .....

Test purpose:

☐ Diagnostic test ☐ Carrier screening

☐ Prenatal test

☐ Other (specify): .....

Clinical indications or condition tested for:

.....

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

1. The test does not detect all genetic changes or predict all possible health conditions.
2. The test may find a genetic change not related to the reason for testing ('incidental finding') (*genomic testing only*).
3. The test may find a genetic change of uncertain significance.
4. More tests or analysis may be needed to understand the results. This may include testing blood relatives.
5. The sample or results may be re-examined in the future using new knowledge or testing methods.
6. Results may have health implications for blood relatives.
7. Results may show unexpected family relationships.
8. Results may affect the ability to obtain some types of insurance.
9. The sample will be stored and may be shared with other laboratories to assist with genomic testing.
10. Results and related health information may be shared with genomic and medical databases that are used for patient care. All identifying information will be removed.
11. Results are confidential and will only be shared with my consent, or as required or permitted by law.
12. I can change my mind about testing, even after the test sample has been collected, and choose not to be told the results. However, if testing has started, a report will remain in my medical records.

The following person can be given the results if I cannot be contacted, including in the event of my death:

Name: ..... Phone number: .....

Information sharing

• I consent to share the results and related information 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 and not without my prior written consent.	☐ Yes ☐ No
• I consent to share the sample, genetic/genomic test data, and related health information for ethically approved research into the same or related conditions. I understand identifying information will be removed and will usually be replaced with a unique code so that information can be returned to me in some situations. I understand that if I no longer want to be involved in research, I can contact my health professional to discuss my withdrawal.	☐ Yes ☐ No
• I am aware and understand that Queensland Health has no governance or control over whether my test report is uploaded to My Health Record (MyHR).	☐ Yes, I understand

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Adapted from Clinical Genetic and Genomic Testing Consent Forms, Version January 2024, developed by Australian Genomics.

Queensland Government

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(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Consent

Patient / proxy:

- I consent to genetic/genomic testing.
- I understand the reason for testing and the potential benefits, consequences and limitations.
- I have been given a copy of the Patient Fact Sheet - Genetic and Genomic Testing (V1.0), which provides information about testing.
- I have been able to discuss the information with a health professional, ask questions and have any concerns addressed.
- I am satisfied with the explanations and answers to my questions.

Name of patient: .....

Patient signature: ..... Date: ...../...../.....

Email address: .....

Genetic file number (if applicable): .....

Or, where consent is given on behalf of another:

Name of proxy: .....

Proxy signature: ..... Date: ...../...../.....

Relationship to patient: .....

Email: ..... Phone number: .....

Health professional:

I, ...

(Name of health professional) *(Signature)*

..../...../.....

(Designation) *(Date)*

have provided information on the reason for and nature of the test, possible results, limitations and material risks of the test.

The patient / proxy has been able to ask questions and consider the answers before completing this form.

Other declarations

Interpreter / Liaison Officer: ☐ Not applicable

I, .../...../.....

(Name of interpreter / Liaison officer) *(Signature)* *(Date)*

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

Consent for parents undergoing duo/trio genomic analysis: ☐ Not applicable

I/we consent to genomic testing for the purpose of assisting in the interpretation of the genomic results of my/our child (the patient named above). I/we understand the reason for testing and the potential benefits, consequences and limitations. Specifically, I/we understand that the details of genomic testing outlined above apply to my/our sample(s), results and related information. I/we have been able to discuss the information with a health professional, ask questions and have any concerns addressed. I/we are satisfied with the explanations and answers to my/our questions.

I/we consent to share my sample, genomic data and related health information for ethically approved research into my/our child's condition. I/we understand that identifying information will be removed and may be replaced with a unique code so that information can be returned to me/us where appropriate.

Genetic mother: ☐ Yes ☐ No

Name: ..... Date of birth: ...../...../.....

Signature: ..... Date: ...../...../.....

Genetic father: ☐ Yes ☐ No

Name: ..... Date of birth: ...../...../.....

Signature: ..... Date: ...../...../.....

DO NOT WRITE IN THIS BINDING MARGIN