**PATIENT DETAILS** [patient label]

**First name(s):**

**Surname:**

**Date of birth:**

**Sex:**

**UR:**

[Service logo and details]

**Clinical Tissue-targeted (Somatic)**

**Genomic Testing Consent Form**

**Clinical indications or condition tested for:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Test purpose:** This test can be used to assist with diagnosis and may help inform treatment options and prognosis.

**It is my choice to have tissue-targeted genomic testing. I understand that:**

1. This test aims to look for genetic changes in the tissue sample that may be related to the condition.
2. The test does not detect all genetic changes or all genetic conditions.
3. Although not intended, this test may find a result that is unrelated to the current condition and/or could have implications for blood relatives.
4. To better understand the test results, more testing, another tissue sample or re-examination may be needed.
5. 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.
6. Results are confidential and will only be shared with my consent, or as required or permitted by law.
7. I can change my mind about testing and choose not to be told the results, but if testing has started a report will remain in patient medical records.

**If I cannot be contacted, the following person can be given the results and I will discuss this test with them:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*NAME CONTACT DETAILS (EMAIL AND PHONE NUMBER)*

**Additional consent**

* If a relevant genetic change has been found, test results and related information can be shared with health professionals to help with the genetic testing of blood relative/s. I understand that identifying information will not be shared with relative/s wherever possible.     □ Yes   □ No

***Optional clause (based on jurisdictional policy/procedural requirements):***

* Test results may be uploaded to My Health Record (MyHR). □ Yes   □ No

**Patient/Proxy Declaration**

* I consent to tissue-targeted genomic testing.
* I understand the reason for testing and the potential benefits, consequences and limitations.
* 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 SIGNATURE DATE*

**Or, where consent is given on behalf of another:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

*NAME OF PROXY SIGNATURE DATE*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *PROXY’S RELATIONSHIP TO PATIENT*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CONTACT DETAILS (EMAIL AND PHONE NUMBER)*

**Health Professional Declaration:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

*NAME OF HEALTH PROFESSIONAL SIGNATURE DATE*

have provided information on the reason for and nature of the test, possible results, limitations and material risks of the test. The patient has been able to ask questions and consider the answers before completing this form.

***Optional (based on jurisdictional policy/procedural requirements):***

**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.