NSW GOVERNMENT Health

Facility:

CONSENT: GENETIC TESTING

(for all types of genetic and genomic testing for SUBSTITUTE CONSENT)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020116

GUARDIANSHIP ACT 1987 (for patients 16 years and above without capacity)

PROVISION OF INFORMATION TO PERSON RESPONSIBLE To be completed by Medical Practitioner

I _____
INSERT NAME OF MEDICAL PRACTITIONER

confirm that _____ is incapable of consenting to genetic testing because:
INSERT NAME OF PATIENT

☐ he/she cannot understand the nature and effect of the genetic test OR;
☐ he/she cannot indicate whether or not he/she consents.

Genetic testing is being conducted for _____

_____
INSERT NAME OF CONDITION(S) OR CLINICAL INDICATIONS

***The proposed genetic test is (please tick an option below):**

☐ **Carrier Testing:** a genetic test performed on a person to identify if they carry a gene change.

☐ **Diagnostic Testing:** a genetic test performed on a person to identify a specific genetic condition.

☐ **Predictive/Presymptomatic Testing:** a genetic test performed on a person with a family history of a genetic condition, who does not usually have symptoms at the time of testing, to determine if they have inherited that condition or susceptibility to that condition.

☐ **Prenatal Testing:** a genetic test to identify possible genetic conditions in an unborn baby.

☐ Other (please specify): _____

_____

The general nature and effect of the test is _____

_____

The significant risks (if any) of having the test are _____

_____

The reasonable alternatives (if any) to the test and significant risks associated with these alternatives are _____

_____

_____

The test is the most appropriate test to maintain the patient's health and wellbeing.

_____ and I have discussed the patient's present condition
INSERT NAME OF PERSON RESPONSIBLE

and the reason for conducting the proposed genetic test*. I have also explained, as acknowledged on the reverse side of this form by *the person responsible* the possible results, limitations and material risk of the proposed genetic test*. *The person responsible* has been offered additional written information and/or reference to online resources about the genetic testing

_____ _____ / _____ / _____
SIGNATURE OF MEDICAL PRACTITIONER DATE

If an interpreter is present:

_____ _____
INSERT NAME OF INTERPRETER SIGNATURE

_____ / _____ / _____ _____ : _____ AM/PM _____
DATE TIME EMPLOYEE ID / PROVIDER NUMBER

NO WRITING

CONSENT: GENETIC TESTING
(for all types of genetic and genomic testing for SUBSTITUTE CONSENT)
SMR020.116

NH700577 150120

NSW GOVERNMENT Health

Facility:

CONSENT: GENETIC TESTING

(for all types of genetic and genomic testing for SUBSTITUTE CONSENT)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PERSON RESPONSIBLE CONSENT

To be completed by Person Responsible

I understand and acknowledge that:

- ✓ The patient's blood, saliva or tissue sample will be used to test their DNA;
- ✓ I will be told the patient's results by a health practitioner;
- ✓ This is not a "general health test";
- ✓ The patient's results are based on current knowledge that may change in the future;
- ✓ This test will not predict all of the patient's future health problems;
- ✓ I can change my mind about the patient having the test performed or about receiving the patient's test results at any time by contacting the health practitioner;
- ✓ There are a number of different possible results from the testing and these can have implications for the patient and their family;
- ✓ The patient's results may be of "unknown or uncertain significance", which means they cannot be understood based on current knowledge;
- ✓ There is a chance that some genetic tests could identify other medical conditions (or susceptibility to other medical conditions) as an incidental finding;
- ✓ The patient's test results may identify unexpected family relationships;
- ✓ The patient's test results may affect their ability to obtain some types of insurance (for example, life insurance);
- ✓ Further testing may be needed to finalise the result;
- ✓ The reason for testing and the potential benefits, consequences and limitations involved in the testing have been explained to me in a way I understand;
- ✓ I have had an opportunity to discuss the information, ask questions and have any concerns addressed and I am satisfied with the explanations and answers to my questions;
- ✓ The patient's results are confidential and will only be released as required or permitted by law.

PERSON RESPONSIBLE CONSENT **(for patients 16 years and above without capacity)**

I consent to genetic testing as discussed with _____

INSERT NAME OF MEDICAL PRACTITIONER

for _____ I have considered the views of the patient and I am satisfied

INSERT NAME OF PATIENT

the genetic test is the most appropriate test for the patient.

_____ _____ _____ / _____ / _____

INSERT NAME OF PERSON RESPONSIBLE | SIGNATURE OF PERSON RESPONSIBLE | DATE

_____ _____

RELATIONSHIP TO PATIENT IN TERMS OF THE ACT | PHONE NUMBER OF PERSON RESPONSIBLE

_____

ADDRESS OF PERSON RESPONSIBLE

NO WRITING