

# MAINSTREAM CONSENT FORM FOR GENETIC TESTING AND STORAGE

Name:

Date of Birth:

NHS Number:

(OR AFFIX HOSPITAL LABEL HERE)

<b>I have discussed genetic testing and I agree to:</b>	
A genetic test for inherited causes of cancer (and DNA storage)	
<b>OR</b>	
DNA storage only <i>If the patient is having DNA stored without testing, proceed to Patient/Practitioner signatures</i>	

<b>Family implications</b>	The results of my test may have implications for other members of my family. I agree that results may be shared with doctors looking after my relatives, where appropriate.	
<b>Uncertainty</b>	The results of my test may reveal genetic variation where the significance is not yet known. I acknowledge that interpretation of my results may change over time as new evidence is gathered.	
<b>Future health implications</b>	I understand that if I am found to have a gene variant, this may inform my risk of developing some other types of cancer, as explained in today's test consultation.	
<b>Further advice</b>	If I am found to have a gene variant, I will be referred to Clinical Genetics. In some cases, I may be referred even if my test is negative.	
<b>DNA storage</b>	I understand that my DNA may be used to help with tests for other family members, or anonymously for quality control purposes.	
<b>Data storage</b>	Data from my genetic test will be stored to allow for possible future interpretations.	
<b>Health records</b>	Results from my genomic test and my test report will be part of my Patient Health Record.	
<b>Other areas discussed (e.g. research, insurance):</b>		

<b>Should I be unable to receive my result, I agree with it being shared to benefit the care of my family. In this situation, I would like my result communicated to:</b>	
Full name:	Relationship:
Address:	Date of birth:

<b>Patient's full name:</b>	
Patient's signature:	Date:
Patient consented remotely? <i>If consented remotely, record patient choices on the form, file one copy in notes and send a second copy to the patient for information</i>	Remote                      FTF

<b>Health practitioner's name:</b>	Role:
Signature:	Date: