NHS
South West
Genomic Laboratory Hub

MAINSTREAM CONSENT FORM FOR GENETIC TESTING AND STORAGE

Name:
Date of Birth:
MRN Number:
NHS Number:
(OR AFFIX HOSPITAL LABEL HERE)

I have discussed genetic testing and I agree to my blood sample being used for the following reason:	
Diagnostic genetic test for genes associated with Lynch Syndrome (and DNA storage)	☐

OR

DNA storage only ***If the patient is having DNA stored without testing, ignore the additional sections and proceed to Statement of Patient / Practitioner to consent for storage alone.***	☐

Family implications	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 - as appropriate.	☐
Uncertainty	The results of my test may reveal genetic variation whose significance is not yet known. I acknowledge that interpretation of my results may change over time as such evidence is gathered.	☐
DNA storage	I understand that my DNA may be used to help with tests for other family members, or anonymously for quality control purposes.	☐
Data storage	Data from my genetic test will be stored to allow for possible future interpretations.	☐
Health records	Results from my genomic test and my test report will be part of my Patient Health Record.	☐
I understand that whether or not a gene alteration is found, I will be referred to Clinical Genetics for advice re: future management		☐
I understand that if I am found to have a gene alteration, this may increase my risk of developing other cancers.		☐
Other areas discussed (e.g. research, insurance)		☐

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:

Full name:	Relationship:
Date of birth:	Address:

Patient's full name:	
Patient's signature:	Date:

Health practitioner section	
Health practitioner's full name:	Role:
Signature:	Date: