Clinical Genetics
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Consent for Testing or Storing Sample

Patient's full name:_____ PRU Number: _____:__

Address: _____ DoB: _____

☐ **adult, capable** ☐ **minor** ☐ incapable of giving consent (stop, see guidance & specific form)

Name of guardian:_____ Contact details: _____

Statement of health professional

I have explained why the test is being offered, any options and these issues to the patient/guardian:

☐ chromosome analysis / rearrangement _____
☐ **blood** / **DNA** / **tissue sample** to be analysed for _____
☐ DNA to be stored _____

	N/A
☐ test may enable relatives to benefit from genetic testing	☐
☐ test may clarify a previous result / confirm a clinical diagnosis	☐
☐ test may reveal unexpected information, including information about a child's biological parents	☐
☐ risk of infection / scarring / need for anaesthesia (only for skin biopsy)	☐
☐ sample may be sent to another laboratory for testing	☐
☐ leftover sample may be used anonymously to help develop new tests	☐
☐ other:_____	☐
☐ the following leaflet will be sent with your clinic letter _____	☐

Signed…….…… Date……..

Name (PRINT) …….. ……. Job title……..

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.
Signed …….. Date…….. Name (PRINT)…….

For the patient or guardian

Please read this form carefully. If you have questions about the risks and benefits of the test, please ask now. You can change your mind about testing, even after agreeing to it.

☐ I agree to this test. I would like results to be given: **in clinic / by post / by phone**
If I am unable to receive the test results, I would like the results to be given to:

Name: _____Relationship: _____

Address: _____ Telephone No: _____

☐ I give permission for test results to be sent to my GP / referring doctor _____
☐ I give permission for relevant results to be available to family members or to their doctors
☐ I would like to be informed before any further testing is done later on
☐ I would like a copy of this form

Signed……Print name ……..Date……
A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here.

Signature …… Date ……Name (PRINT) ……

☐ Patient has withdrawn consent: Patient signature …… Date……...