Consent Form—Gene Panel Testing

mater pathology

I, _____, date of birth _____, consent to my/my child's (name of child _____, date of birth _____), blood/DNA sample to be analysed for the gene panel as indicated by my doctor on the attached test request form. I have been provided with a copy of this consent form and have had an opportunity to discuss with my referring doctor the benefits, limitations and risks of undergoing this type of testing.

I understand the following:

- The results of this test will be made available to me via the medical practitioner requesting the test. The laboratory will not release results directly to patients as a matter of safety as the results may require expert clinical interpretation. Results will not be released to other individuals without my consent except where required by law.
- Testing is completely voluntary, I may withdraw from testing at any time by contacting the laboratory on Telephone: +61 7 3163 6017. (Note: depending on the progress made in testing your sample, some or all fees may still apply).
- Testing may generate any of the following results:
  - **a.** A disease causing, or likely disease causing, change is identified in one or more of the genes analysed and is thought to be the cause of the clinical condition in question.
  - **b.** A change that is of unknown or of uncertain significance is identified in one or more of the genes analysed. This means that, given current understanding of the gene(s) involved, the laboratory is unable to say whether the gene change identified is the cause of the clinical condition in question.
  - **c.** Testing may identify a change in one or more of the genes analysed which represents normal, or likely normal, variation in the gene and which is not thought to be the cause of the clinical condition in question. Similarly, testing may not identify any changes in the genes being analysed. The outcome in both circumstances is the same—the test is unable to clarify the cause of the clinical condition being investigated. This may be because either i) the clinical condition in question is not due to a genetic change; ii) the clinical condition is due to a genetic change in a gene not analysed as part of this test; or iii) the clinical condition is due to a change in one of the genes analysed but for technical reasons the test method used was unable to detect it.
- Should testing identify a disease causing change in one or more of the genes being analysed, the result may have significant medical implications for my extended family members. My result may be used by the laboratory in a de-identified manner to assist in the result interpretation of other family members undergoing testing.
- The results of this test may affect my ability to obtain certain types of insurance, such as life insurance. Please seek independent advice from a financial advisor if this is of concern to you.
- My DNA sample will be stored for a period of at least 1 year, after which it may be destroyed in accordance with standard laboratory practice.
- My sample and clinical information provided may be de-identified and used by Mater Pathology for further test validation or Human Research Ethics Committee (HREC) approved research.
  Yes ☐ / **No** ☐ (Please tick)

Signature _____ Date _____

Requesting Health Professional

Print name _____

Signature _____ Date _____