Consent Form—Cascade 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 change(s), previously detected in a family member, as indicated by my doctor on the attached test request form. (Note: testing of an asymptomatic child may only be requested through a clinical genetics service). 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 having this type of testing performed.

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.** You (or your child) are found to have inherited the gene change(s) previously identified in an affected family member. This result means that you (or your child) are at risk of developing the clinical condition in question.
  - **b.** You (or your child) are not found to have the gene change(s) previously identified in an affected family member. This result means that you (or your child) are not at increased risk of developing the clinical condition in question due to the gene change(s) found in your family. Please note that this does not rule out the possibility of developing a clinical condition due to other genetic causes.
- Test results may have significant medical implications for me and my extended family members. My test results may also infer the gene status of another relative. In some circumstances, testing may reveal non-paternity.
- 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 _____