|  |  |
| --- | --- |
| ***Patient name:*** |  |
| ***Date of birth:*** |  |
| ***Genetics file number:*** |  |
| ***Hospital number:*** |  |
| ***NHS number:*** |  |
| ***Contact number/email:*** |  |



**Record of discussion regarding testing and storage of genetic material**

I have discussed genetic testing for

and I understand that:

***Family implications***

1. The results of my test *may* have implications for my relatives. I acknowledge that my results may be used to inform the appropriate healthcare of relatives in a way that is not explicitly personally identifiable.

***Uncertainty***

1. The results of my test *may* reveal genetic variants of uncertain significance. Establishing whether such variants are significant may require (inter)national comparisons. I acknowledge that interpretation of my results may change over time as our understanding increases.

***Unexpected information***

1. The results of my test *may* reveal information relevant to other diseases that are not related to why this test is being done. These may be found by chance and further investigations may be needed to assess their significance. If additional findings are found, I will be given more information about this. The test may reveal non-paternity/maternity.

***DNA storage***

1. Normal laboratory practice is to store the DNA extracted from my sample even after the current testing is complete. My sample may be used as a ‘quality control’ for other testing, e.g. that of family members.

***Data storage***

1. Data from my test will be stored to allow for possible future interpretations.

***Health records***

1. Results from my test and my test report will be part of my patient health record.

***Insurance***

1. The results of this test *may* have implications for insurance. Please refer to the Association of British Insurers (ABI) UK Code on Genetic Testing and Insurance for further guidance.

Note of other specific issues discussed (e.g. referral to particular research programmes):

**I will be informed of the results by:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (Patient/Parent): \_\_\_\_ \_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_**

**If I am unable to receive the results (e.g. due to permanent severe illness/death), I would like them to be given to**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_ / \_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**