Genomics Consent Form

(Complete a form for each patient sampled)

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All the information contained within this consent form will be kept confidential.

MBG No.

Patient Last Name		**First Name**		**DOB**	MM/DD/YYYY
Patient Emirates ID		**MRN No**			

Type of Genetic Testing:	**Intended Purpose**	**Sample from**	**Proband Details** (if different to above)
☐ WGS *(research use only)* ☐ WES *(include a consent form for each family member)* ☐ Targeted gene panels *(inherited disorders)* Specify: _____ ☐ Solid Tumour Testing ☐ Other, specify: _____	☐ Diagnostic ☐ Screening ☐ Carrier Status ☐ Other, specify: _____	☐Proband ☐Parent ☐Sibling ☐Cousin ☐Other, specify: _____	Name and details of Proband: _____

To be completed by the Patient/Authorised designee

1. I understand that I must seek genetic counselling before signing the consent and proceeding with the test.
2. The nature, purpose, limitations, benefits and risks of Genetic testing have been satisfactorily explained to me by my health professional (Physician / Genetic Counsellor).
3. I understand the implications of possible test results and that MBG Centre will issue the test report to the authorised health professional only.
4. I understand that only the genes known to cause the condition (or part of specific gene panel) will be analysed and included in the report i.e. incidental findings found in genes not related to the specific condition in question will not be reported.
5. I understand that only previously confirmed results will be reported (i.e. only 'Pathologically Confirmed' or 'Likely to be Pathogenic' variants).
6. I understand that Incidental Findings (Pathogenic Variants not related to my specific condition) may be observed. I wish to be informed of all incidental findings YES ☐NO ☐*(Tick & initial).*
7. I understand that upon completion of the genetic analysis, my sample and genetic information will be kept confidential and stored at the MBG Centre for 2 years; after which time it will be destroyed (see no.8).
8. My de-identified retention sample and genetic information may be used by MBG Centre for the purposes of benefiting others with a similar condition. YES ☐ NO ☐*(Tick &initial).*
9. I understand that future knowledge of genetic conditions will likely improve and may impact on the analysis of my current genetic testing results. (A copy of the raw data is available upon written request should I wish to pursue further genetic analysis in the future).
10. I understand that this consent form is intended to be used together with the patient information booklet. I have had the opportunity to ask additional questions, and I am satisfied with the explanations.

To be completed by authorised Health Professional

1. I, _____ have explained to the patient/authorised designee about the nature, purpose, limitations, benefits and risks of genetic testing. We have discussed the consequences and I have explained the procedures involved in sample retention and storage of patient data.
2. I assume responsibility for requesting these genetic tests and for reporting the results to my patient.

Signatures

I consent to have a sample taken for genetic testing on the above-named patient.

Signature of Patient/ Authorised designee	Print Name of Patient
Signature of Health Professional	Date

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