

## **Consent for Genetic Testing**

## Details of the person whose sample is to be tested

Surname	Hospital No	Consultant:	
Forename	NHS No:	Ward/Dept.:	
Date of Birth		Telephone No:	
Address			
Post Code:	Affix Label		
I consent to my genetic	c material being tested for cha	inges to the breast and ovarian cance	er genes -
BRCA1,BRCA2 and F	ALB2 genes.		
I understand that the r	esults may have implications f	or me and my family.	
•	opportunity to discuss these in arding my condition and any to	nplications, to ask questions and to reest currently available.	eceive verbal and
I understand that:			
Any genetic ma	aterial remaining after testing i	s completed will be stored in the labo	ratory.
In some disord	ers having a genetic test may	affect my position with insurance com	npanies
I will be informed of the	ne results by	(telephone, p	ost, in person)
I give my consent for	my doctor to be informed of the r	esults.	*Yes / No
,	the results to be shared with othen nembers of the family, if appropria	er members of the medical community ate.	*Yes / No
I give my consent for	the results to be shared with othe	er members of the family, if appropriate.	*Yes / No
Patient			
Signature of Person givir	ng consent	Print	
Date			
Interpreter (If consent is	given via an interpreter they sho	ould sign this section)	
I confirm I have accurate above patient.	ly translated all the information	provided by the consenting Clinician/Spe	ecialist Nurse to the
Signature	Print	Date	

## **Professional**

I the undersigned confirm	that I am trained to consent for $% \left\{ 1,2,\ldots ,n\right\}$	genetic testing, I have explained the nature an	d
implications of genetic tes them a written informatio		arian cancer genes to the above patient and h	ave given
Name of clinician obtainin	g consent	GMC/NMC No	
Signature	Print	Position	

Copy: 1. Patient 2. Patient File 3. Enclose a copy with the patient's blood sample for the DNA lab.