NHS
The Leeds Teaching Hospitals
NHS Trust

YORKSHIRE REGIONAL GENETIC SERVICE
Department of Clinical Genetics - 3rd Floor,
Chapel Allerton Hospital, Chapeltown Road, LEEDS, LS7 4SA

RECORD OF DISCUSSION ABOUT GENOMIC INVESTIGATION

Sticker with Patient Details

I agree to genetic testing for: .....

I have received information about potential implications for me and my family and I understand that:

Relevant genomic information may be shared to assist genetic counselling for my family.

My sample will be stored after analysis and may be used to assist testing in my family.

A genomic result may affect insurance for me and / or my family.

Genomic data relating to the above condition / genes will be analysed; additional data may be stored but not analysed.

Genomic tests may give information which is unexpected and / or difficult to interpret.

Where applicable, I agree to clinical photographs being taken and used in clinical meetings to assist in interpreting genomic results.

Understanding of genomic results may change in the future and an updated report might be issued.

Information may be used for audit purposes and may be entered into databases or registers to help improve genomic services. Stored samples may be used anonymously for the development of new tests and quality checks.

Signature of patient / parent / guardian: .....

Name *(please print)*: .....

If applicable, relationship to patient *(please tick)*: Parent ☐ Guardian ☐ Other ☐ .....

Date: .....

Where applicable: If I am unable to receive the results (e.g. in the event of my death or permanent incapacity), my family is best contacted through:

Name: ..... Relationship: .....

Contact details: .....

I confirm that I have explained the purpose, nature and implications of the test.

Signature of Clinician: ..... Name *(print)*: .....

Designation: ..... Date: .....

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RECORD OF DISCUSSION ABOUT SAMPLE STORAGE

Sticker with Patient Details

I agree to storage of my sample for possible future genomic testing.

I have received information about potential implications for my health and for my family members.

I understand that storing a sample now does not mean that it will necessarily be tested in the future.

I understand that efforts will be made to contact me before organising any future genomic testing.

In the event of my death or permanent incapacity I agree that my sample can be used to help other members of my family.

Signature of patient / parent / guardian: .....

Name *(please print)*: .....

If applicable, relationship to patient *(please tick)*: Parent ☐ Guardian ☐ Other ☐ .....

Date: .....

Where applicable: If I am unable to be contacted (e.g. in the event of my death or permanent incapacity), my family is best contacted through:

Name: ..... Relationship: .....

Address details: .....

.....

I confirm that I have explained the purpose, nature and implications of sample storage for possible future genetic testing.

Signature of Clinician: ..... Name *(print)*: .....

Designation: ..... Date: .....