Record of discussion about

INHERITED CANCER GENETIC TESTING and STORAGE OF GENETIC MATERIAL

Patient details (or Affix patient label)		
	Surname:	First name:
	Date of Birth:	MRN:
	Patient Address:	

Test Details

Select test:	☐ BRCA 1 / 2 ☐ Breast/Ovarian Panel* ☐ Lynch Syndrome Panel ☐ Pancreatic Panel * Breast cancer includes high grade ductal carcinoma in situ (DCIS); Ovarian includes primary peritoneal, fallopian tube, or serous tubal intraepithelial carcinoma (STIC)	☐ Polyposis Panel ☐ Prostate Panel ☐ Other:
Reason for test:		

I have discussed genetic testing with my healthcare professional and I understand:

1. The potential outcomes, implications and limitations of the test.
2. A copy of my genetic test result may be sent to my referring consultant and GP.
3. The results of my test will be part of my healthcare record.
4. My DNA sample and genetic data may be stored for …….. (duration) by the testing laboratory (Lab Name) _____, in accordance with their policy.
5. I understand that a small number of genetic test results can change over time as cancer genetic testing and knowledge develops.
6. The results may be of "Unexpected" "or "uncertain significance", which means they cannot be understood based on current knowledge.

Note of any additional discussions

E.g. referral to a particular research programme, specific tests, timescale for results, patient wishes to opt out of A, B or C etc.:

CONSENT

A. I agree to the genetic testing discussed and named in the Test Details section above
B. I agree that my genetic test result can be used to facilitate the counselling and testing of family members
C. I agree that my DNA sample may be used to aid genetic testing for my family members.

Patient/Nominated Representative/Guardian:

_____ _____ _____

Name (PRINT) Signature Date

If I am unable to receive the results of the test, I would like the result to be given to the following person(s)

Name: _____Relationship: _____Contact no: _____

Discussion undertaken by Clinician

_____ _____ _____

Name (PRINT) Signature: Date

Clinician Role: _____

Name of treating Consultant: _____

There was a need for an interpreter to be present for this discussion? Yes: _____ No: _____

Interpreter Name: _____ Contact: _____

One COPY for notes and one COPY for patient to retain