

NATIONAL CENTRE FOR MEDICAL GENETICS

OUR LADY'S HOSPITAL FOR SICK CHILDREN

CRUMLIN, DUBLIN 12

www.genetics.ie

Consent Form for Diagnostic Genetic Testing

.....

I understand that it is possible to have a genetic (DNA) test to confirm whether or not I have < disease name here > ("the disorder") and I wish to proceed with this test. I have been fully informed about the test. I understand that the test will show **one** of the following:

1. That I do have the disorder and that other family members may therefore be at risk of developing this condition
2. That I do not have the disorder
3. That the test results are indeterminate or difficult to interpret

Name (block capitals) _____

Address _____

Date _____ Hospital _____ Hospital # _____

Signature of patient _____

Signature of spouse/partner _____ (not essential, but preferred if applicable)

For medical staff:

I have explained the principles and implications of testing for the disorder to the above. I **have reason to believe that this patient has the disorder, as opposed to being at risk due to family history, with/without unrelated symptoms.** I believe this test to be in the best interests of the patient.

Signature _____ Name in capitals _____

Please send this completed form to Dr S. McQuaid at the above address