Accredited Medical Laboratory
Reference No: 3001

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National Centre for **Medical Genetics**
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Consent Form for Diagnostic Molecular Genetic Testing

I understand that it is possible to have a genetic (DNA) test to confirm whether or not *I have/my relative has* < 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/he or she does have the disorder, and that other family members may therefore be at risk of developing this condition
2. That I do not/he or she does not have the disorder
3. That the test results are indeterminate or difficult to interpret

This form must be filled out completely, using BLOCK CAPITALS

Surname:		First Name(s):	
Hospital No:	Date of Birth (DOB):	NCMG Pedigree No (internal use):	SEX:
Home Address:		Consultant/GP: Ward/Clinic/Surgery address & contact number:	

Signature of patient ____

Signature of spouse/partner (not essential, but preferred if applicable:_______________________________________

OR Signature of next-of-kin ____

& (relationship to patient) ____

For medical staff:

I have explained the principles and implications of this testing to the patient/their next-of-kin. **I have reason to believe that this patient has the disorder, as opposed to being at risk due to family history; I have indicated the relevant clinical details on the accompanying request form.**

Signature ______________________ Name in capitals ____________________

Contact phone number:____

Please send this completed form to the Duty Scientist at the above address

Important note: The complete history of this document including its owner, author and revision date can be found on Q-Pulse

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