Affix identifier information here

**Parent/ Guardian Clinical Consent Form for Genomic Testing**

It is my choice for my child/person under my care to have genomic testing.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian name) understand that my child’s/ the person under my care’s DNA will be tested by panel/exome/genome to look for changes in genes that may be associated with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (condition or clinical indication)

**About the Test**

* Genomic test results are based on current knowledge, which may change in the future.
* If I change my mind, I can choose not to be told about the result.

**Potential Outcomes**

* This test might find a cause for the condition(s).
* This test might not find a cause for the condition(s).
* The result might be of *‘unknown significance*’, which means it cannot be understood today.
* There is a chance that genomic testing could find other medical conditions (incidental findings).
* Genomic testing may show unexpected family relationships.
* Further tests or information sharing may be needed to finalise the result.

**Results**

* I will be told the results by a health professional.
* Results may have implications for the health/genetic risks for my child/the person under my care and family members.
* Results can be used to inform counselling and testing of family members, though my child’s/ the person under my care’s identity will not be revealed to them.
* Results from these tests may affect my child’s/ the person under my care’s ability to obtain some types of insurance.
* The results will be available to health professionals involved in the care of my child/the person under my care.
* Results are confidential and may not be released without my consent, unless allowed by law.
* The following individual can be given my child’s/ the person under my care’s results, if I am unable to be contacted:

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Data and Sample Sharing**

My child’s/person under my care’s **de-identified** sample, genomic data and related health information may be shared and stored to help advance scientific knowledge. Information cannot be returned to me. There will not be a direct benefit to my child/person under my care and family members.

**Research**

I provide consent to share my child’s/person under my care’s sample, genomic data and related health information for ethically-approved research into the same or a related condition, where it remains possible to re-identify them. This allows information to be returned to me where appropriate. There may not be a direct benefit to my child/person under my care and family members.  **□ Yes        □ No**

**I have had enough time to consider the information in this consent form and have:**

* Had the opportunity to discuss genomic testing and its implications with a health professional
* Been given access to information about genomic testing.
* Been able to ask questions until I am satisfied with the answers.
* Been offered a copy of this consent form.

**I provide consent to have genomic testing as summarised in this form.**

Print Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent/ Guardian’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email/ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Professional Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Professional Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_