

INFORMED CONSENT FOR GENETIC TESTING

I, _____ request that the Retinoblastoma Genetic Screening Unit analyse blood and/or other tissue samples (e.g. tumour, CVS, saliva, hair) from me and/or my child(ren) for retinoblastoma predisposition. **I understand that the supplied samples will be used to determine if I and/or members of my family carry a genetic abnormality believed to predispose to retinoblastoma tumours.**

By signing below, I acknowledge that:

1. The possible outcomes of this test are:
 - The test result may indicate that it is likely that the disease gene has been inherited.
 - The test result may indicate that it is unlikely that the disease gene has been inherited.
 - **The test results may not be informative.**

2. An error in diagnosis may occur if the biological relationships of the family members, as detailed on the request form(s), are incorrect.

3. There is a low probability of human error and a remote possibility of a second mutation not identified by the test.

4. The sample, and the test results from this sample, may be used in genetic risk assessment of other members of my family and made available to their health professionals unless otherwise requested.

5. Residual samples are retained and stored for future diagnostic testing, unless otherwise requested. These may be used for developing new tests, as quality controls or in an anonymous fashion for retinoblastoma research.

6. My referring clinician reviewed this consent form with me and explained the implications of the test results.

Signature of Patient or Consenting Parent

Date

Statement of Referring Clinician: I reviewed this form with the patient. I offered to answer any questions regarding personal genetic information for the patient or the patient’s children.

Signature of Referring Clinician

Date

Name	RGSU Request Form		
Q Pulse ID	RBFORM_010	Copy Location	
Version	13	Author	Zerrin Onadim
Date of Issue	Jan 2019	Authoriser	E Price
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