PathWest
LABORATORY MEDICINE WA

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Consent Form – Genetic Testing for Cardiometabolic Disorders

I, _____, consent to genetic testing on my/my child's sample for a panel of genes known to cause inherited cardiometabolic disorders.

I understand that:

- In order to assist in the interpretation of this genetic test, relevant clinical information will need to be provided.
- Test results will be made available to me via the medical practitioner requesting the test.
- Test results may have implications for children and/or other family members.
- Results are confidential and may only be released to family members or authorities with consent or as required by law.
- Testing will not affect the ability to obtain health insurance but may affect applications for some types of life insurance.
- Samples and data will be kept for the period required by laboratory regulations.
- Interpretation of genetic test results is based on the best evidence at the time of reporting; additional analysis will only periodically be undertaken after a report is issued.
- Possible outcomes of genetic testing:
    - One or more disease causing (pathogenic), or likely disease causing, genetic changes are identified.
    - Analysis did not detect any clinically relevant genetic changes. This may be because the clinical condition is (a) not due to a genetic change, (b) is due to a genetic change in a gene not analysed in this test, or (c) is due to a change in one of the genes analysed but for technical reasons the test method was unable to detect it.
    - A genetic change of uncertain significance. This means that based on current knowledge of the gene(s) involved, the laboratory is unable to say whether the genetic change is the cause of the clinical condition.
    - Genetic risk factors for cardiac and metabolic conditions may be identified.

Patient name: _____ Patient DOB: ___/___/_____

Signature (patient/guardian/next of kin):_____ Date: ___/___/_____

Medical Practitioner Statement

I have explained the nature, limitations, likely results and risks associated with the requested genetic test to this person and answered his/her questions.

Requesting Health Professional (print name): _____

Signature:_____ Date: ___/___/_____