Manchester University
NHS Foundation Trust

CONSENT TO TEST FOR A FAMILIAL MUTATION/VARIANT
(a virtual version is available on Hive)

Part A:

Details of individual to be tested:	**Please return completed form to:**
Name: DOB: NHS/Reference number:	The Manchester Centre for Genomic Medicine 6th Floor, Saint Mary's Hospital Oxford Road Manchester M13 9WL. **Requested by:**

A ticked box indicates testing will require: A fresh blood sample ☐
Access to a stored sample ☐

Part B: By signing this form I understand the following:

- A sample of my DNA (or that of my child or deceased relative) will be tested for the following genetic change(s)……..
- The potential implications and limitations of this test have been explained as far as current knowledge allows. I am aware that new information may emerge in the future.
- The results of this test could have implications for myself and/or other family members including (future) children.
- My sample and genomic data will be securely stored in case future relevant tests become available.
- My test results and/or DNA sample may be used by health care professionals in the UK to help interpret the result of genetic testing and/or clarify the risks in other family members.

Name of individual giving consent	Signature	Date

Part C: If signing on behalf of your child or deceased family member please indicate

Your Contact Address	Telephone Number	Relationship (eg mother)

Name of the clinician taking the consent	Signature	Date