Manchester University
NHS Foundation Trust

CONSENT FOR A GENOMIC TEST

I agree for a sample from myself / my child / my deceased relative to be tested to look for genetic changes

potentially linked to:

Details of person whose sample is to be tested:	**Please return completed form to:**
Name: DOB: 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 ☐

Possible results:

- A change may be found that is the whole or at least partial cause of the condition. It may have other health implications for me and / or other family members.
- No differences may be found i.e. testing may not find the cause of the condition now, but the data could possibly be reanalysed with new technology in the future.
- A change may be found that cannot be interpreted with current scientific knowledge. Further family studies or research may help to clarify the significance now or at some point in the future.
- In rare situations, a change may be found that is not thought to be the cause of the condition being investigated but could have other implications for me and / or other family members.

By agreeing to have the test I understand the following:

- 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