Record of Discussion – Genomic testing

Patient details (*affix patient's addressograph label or print*)
Patient name: Date of birth: NHS No:

I have discussed genomic testing with my health care professional and understand the following:

Family implications

The results of my test may have implications for me and my relatives. I understand that my results may also be used to help inform the healthcare of my relatives. This could be done in discussion with me or through a process that will not personally identify me.

Uncertainty

The results of my test may have findings that are uncertain and not yet fully understood. To decide whether findings are significant for myself or others, my data may be compared to other patients' results across the UK or internationally. I understand that the interpretation of my results may change over time and may alter my treatment options.

Unexpected information

The results of my test may reveal unexpected findings that are not related to why I am having this test. These may be found by chance and I may need further tests or investigations to understand their significance.

DNA storage

NHS laboratory practice is to store the DNA extracted from my sample even after my current testing is complete. My DNA might be used for future analysis and/or to ensure testing in other is of high quality.

Data storage

Data from my genomic test will be stored securely, so that it may be looked at again in the future, if necessary.

Health records

My genomic tests results will form part of my NHS Wales medical records and may be accessed by NHS staff involved in my care

Note issues discussed (e.g. test offered, referral to research programmes, insurance)

I confirm I have had the opportunity to discuss information about genomic testing.

I agree to genomic testing **YES** ☐ **NO** ☐

Patient name	**Signature**	**Date**
_____	_____	____/____/_____

If you are signing this form on behalf of someone else (children, adults or deceased patients), please sign below

Parent/Guardian/consultee name *please amend as appropriate*	**Signature**	**Date**
_____	_____	____/____/_____

Should I be unable to receive my result, I agree with it being shared to benefit the care of my family. In this situation, I would like my result communicated to:

Full name:	Relationship:
Address:	Date of birth:

Health Care professional use only

To be completed by the healthcare professional recording the patient's choices

Patient category	❑Adult (made their own choice ❑Adult lacking capacity (choices advised by consultee) ❑Child (parent or guardian choices)	❑Clinician agreed to test (in patient's best interest) ❑Deceased (choices made on behalf of deceased individual)
Test type	❑Rare and inherited diseases	
Remote consent	❑Recorded remotely by clinician, no patient signature	
Responsible clinician		
Hospital number		

Healthcare professional name	**Signature**	**Date**
_____	_____	____/____/_____