GENETIC HEALTH SERVICE
NEW ZEALAND
RATONGA HAUORA IRANGA
AOTEAROA

For WRGL use only

REC	
DATE / TIME	
SAMPLE	
VOL / CONDITION	
TEST REQUIRED	

PLEASE DO NOT PUT ANYTHING IN THIS BOX

Consent for Genetic Testing and /or DNA Storage

Patient details

Genetic testing may be used to establish a diagnosis or to determine risk status
Consent is given for:

Test:_____ **/ DNA Storage Only** (circle)

Sample: **Blood** **Urine** **Tissue** **Other** _____

1. The purpose of this genetic testing is:
   (a) For my care and treatment ..... YES ☐ NO ☐
   (b) To understand implications for my whānau/family ..... YES ☐ NO ☐
2. If I am unable to receive results, they will be discussed with my representative or nominated person
3. Genetic testing may reveal information about biological whānau/family relationships
4. Genetic testing may reveal incidental findings that are unrelated to the condition being investigated
5. GHSNZ may share genetic information to benefit whānau/family accessing genetic healthcare – unless noted overleaf.
6. GHSNZ will not further share genetic information unless required or permitted to do so by law
7. Genetic testing for some conditions may only be available overseas
8. DNA will be stored in laboratories involved in this testing
9. Stored DNA/tissue may be returned or destroyed on request
10. Stored DNA may be used as a laboratory control sample or for Quality Assurance purposes
11. Genetic testing may have insurance implications
12. Consent for genetic testing can be withdrawn at any time prior to testing

I understand the information above and overleaf and I have had the opportunity to ask questions

Signed:_____ **Date:**_____
Patient/Parent//Representative

Signed:_____ **Date:** _____
Health Professional

Representative or nominated individual to be sent genetic results in the event I am unable to receive them

*Name:*_____ *Relationship:*_____

*Address:*_____ *Telephone:*_____