



# Genetic Testing Consent Form

1. I have read and understood the CardioGenetics Information leaflet

Yes

No

2. I realise that Genetic testing is voluntary not mandatory

Yes

No

3. I consent to undergoing the following Genetic test \_\_\_\_\_

Yes

No

4. I understand that my Genetics test results have implications for my family and that they will be shared with them and the medical / nursing team members looking after them

Yes

No

5. I understand that a negative gene test does not rule out the presence of a heart condition

Yes

No

6. I understand that having a pathogenic gene variant does not mean that I will definitely develop the condition associated with that gene variant

Yes

No

7. I understand that a variant of unknown significance may be discovered which for now will be non-actionable until its role is potentially clarified by future research

Yes

No

8. I understand that there is always a small chance of sequencing inaccuracy or incorrect variant interpretation despite all our efforts to prevent such occurrences

Yes

No

9. I agree to my clinical and genetic data being stored in my Mater Hospital patient chart, in our FHSC family folder, in the Clinic and national Inherited Cardiac Conditions registries when they are developed. Data will be stored in accordance with Irish Data Protection Act.

Yes

No

10. I am aware that a clinical exome consisting of more than 6,000 genes will be sequenced and the data stored in the NGS Lab indefinitely. However only the relevant gene panel named above will be analysed for gene variants and reported on.

Yes

No

11. I understand that because this is a focused gene panel only looking at gene variants that could cause my condition or conditions like it that it is most unlikely that secondary or incidental variants will be found. If they are found I do / do not (cross out as appropriate) wish to be notified about them.

Yes

No

12. I am aware that an aliquot of my DNA will be kept in Mater NGS Lab for at least 5 years for quality control and assurance purposes.

Yes

No

13. I am willing to be contacted if there is potential for my test results or DNA sample being involved in future research studies. These will not occur without my explicit consent

Signature: \_\_\_\_\_

Date: \_\_/\_\_/\_\_

Physician: \_\_\_\_\_

Date: \_\_/\_\_/\_\_



## The Family Heart Screening Clinic

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