GUARDIANSHIP ACT 1987 (for patients 16 years and above without capacity)

PROVISION OF INFORMATION TO PERSON RESPONSIBLE
To be completed by Medical Practitioner

I __________________________________________________________________________________________________________________

INSERT NAME OF MEDICAL PRACTITIONER
confirm that ____________________________________________________________________________________________ is incapable of consenting to genetic testing because:

☐ he/she cannot understand the nature and effect of the genetic test OR;
☐ he/she cannot indicate whether or not he/she consents.

Genetic testing is being conducted for ______________________________________________________________________________
___________________________________________________________________________________________________________________

INSERT NAME OF CONDITION(S) OR CLINICAL INDICATIONS

*The proposed genetic test is (please tick an option below):

☐ Carrier Testing: a genetic test performed on a person to identify if they carry a gene change.
☐ Diagnostic Testing: a genetic test performed on a person to identify a specific genetic condition.
☐ Predictive/Presymptomatic Testing: a genetic test performed on a person with a family history of a genetic condition,
who does not usually have symptoms at the time of testing, to determine if they have inherited that condition or
susceptibility to that condition.
☐ Prenatal Testing: a genetic test to identify possible genetic conditions in an unborn baby.
☐ Other (please specify):
___________________________________________________________________________________________

The general nature and effect of the test is ______________________________________________________________________________
___________________________________________________________________________________________________________________

The significant risks (if any) of having the test are ______________________________________________________________________________
___________________________________________________________________________________________________________________

The reasonable alternatives (if any) to the test and significant risks associated with these alternatives are ______________________________________________________________________________
___________________________________________________________________________________________________________________

The test is the most appropriate test to maintain the patient’s health and wellbeing.

___________________________________________________________________________

and I have discussed the patient’s present condition
___________________________________________________________________________

and the reason for conducting the proposed genetic test*. I have also explained, as acknowledged on the reverse side of this
form by the person responsible the possible results, limitations and material risk of the proposed genetic test*. The person
responsible has been offered additional written information and/or reference to online resources about the genetic testing
___________________________________________________________________________

SIGNATURE OF MEDICAL PRACTITIONER __________ / ________ / DATE

If an interpreter is present:

__________ / ________ / ________ __________ / ________ / AM/PM

SIGNATURE

DATE

TIME

EMPLOYEE ID / PROVIDER NUMBER

NO WRITING
To be completed by Person Responsible

I understand and acknowledge that:

✓ The patient’s blood, saliva or tissue sample will be used to test their DNA;
✓ I will be told the patient’s results by a health practitioner;
✓ This is not a “general health test”;
✓ The patient’s results are based on current knowledge that may change in the future;
✓ This test will not predict all of the patient’s future health problems;
✓ I can change my mind about the patient having the test performed or about receiving the patient’s test results at any time by contacting the health practitioner;
✓ There are a number of different possible results from the testing and these can have implications for the patient and their family;
✓ The patient’s results may be of “unknown or uncertain significance”, which means they cannot be understood based on current knowledge;
✓ There is a chance that some genetic tests could identify other medical conditions (or susceptibility to other medical conditions) as an incidental finding;
✓ The patient’s test results may identify unexpected family relationships;
✓ The patient’s test results may affect their ability to obtain some types of insurance (for example, life insurance);
✓ Further testing may be needed to finalise the result;
✓ The reason for testing and the potential benefits, consequences and limitations involved in the testing have been explained to me in a way I understand;
✓ I have had an opportunity to discuss the information, ask questions and have any concerns addressed and I am satisfied with the explanations and answers to my questions;
✓ The patient’s results are confidential and will only be released as required or permitted by law.

PERSON RESPONSIBLE CONSENT (for patients 16 years and above without capacity)

I consent to genetic testing as discussed with ____________________________________________________________

for ____________________________________________ I have considered the views of the patient and I am satisfied
the genetic test is the most appropriate test for the patient.

___________________________________________________________      ______________________________      _____

/     /

INSERT NAME OF PERSON RESPONSIBLE SIGNATURE OF PERSON RESPONSIBLE                        DATE

_________________________________________________________________     _______________________________________________

RELATIONSHIP TO PATIENT IN TERMS OF THE ACT                         PHONE NUMBER OF PERSON RESPONSIBLE

ADDRESS OF PERSON RESPONSIBLE