BIOCHEMISTRY DEPARTMENT, ST JAMES'S HOSPITAL, DUBLIN
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Consent form for Diagnostic Genetic Testing on patient

Name: _____

DOB: _____

1. I, _____, request that an attempt be made using genetic material (either DNA, RNA or both) to assess the probability that: I / my child (DELETE WHERE NOT APPLICABLE) might have inherited a disease-causing mutation in the gene ***HFE*** such mutations being associated with susceptibility for the medical condition ("disorder") **Hereditary Haemochromatosis**.

2. In wishing to proceed with this test I have been fully informed about the test. I understand that the test will show **ONE** of the following:

a. That I do have the disorder or carry a strong genetic susceptibility for the disorder and that other family members may therefore be at risk of developing this condition.
b. That I do not have the disorder
c. That the test results are indeterminate or difficult to interpret.

Name: _____

Address: _____

Hospital: _____

Hospital registration number: _____

Signature of patient/parent/guardian: _____

Date: _____

_____

For Medical Staff:
I have explained in detail to the above patient the principles and implications of genetic testing for the disorder. Given the clinical information available at this juncture I believe this test to be in the best interests of the patient.

Signature: _____ Date: _____

Name (Printed): _____

Medical Council registration number: _____