Department of Anatomic Pathology
Parkway Laboratories
2 Aljunied Avenue 1
#07-11 Framework 2 Building S389977
Hotline: 6933 0801 Fax: 6334 2387
E-mail: sgapadmin@parkwaypantai.com

CONSENT FOR GENOMIC TESTING

1. I, the undersigned patient/parent/guardian/donee/court-appointed deputy*, consent (on behalf of the patient)* to undergo the procedure of genomic testing.

2. I confirm that I understand the nature and purpose of the genomic testing requested.

3. I confirm that I have been provided adequate pre-test counselling and that I understand the cost, benefits, limitations, and material risks and implications of the genomic testing.

4. I confirm that I have been explained on any foreseeable consequences that could arise out of the genetic test including but not limited to i) psychological stress, ii) impact on insurability and employment, iii) implications on family members.

5. I understand that there is a small possibility of inaccurate/inconclusive results, notwithstanding the adequate and appropriate care taken to process my specimen, due to the possible reasons:
   5.1. Sampling problems, e.g. poor specimen/specimen quality/specimen inadequacy
   5.2. Technical problems e.g. rare variations in the DNA/RNA of the individual, inability to test to detect rare or previously unknown mutations
   5.3. Presence of mutations or variations of which the significance is yet to be researched/understood

6. I understand that I can withdraw from the testing process at any time, including choosing not to learn of the results or postponing the receipt of the test results obtained. I understand that I will be charged a fee determined by Parkway Laboratory Services Ltd and will not be refunded of any amount paid if the analysis of the specimen is already underway.

7. I understand that the results of the test will be communicated to me through the requesting clinician and that I will have to undergo post-test counselling with the requesting clinician after the results of the testing has been made available to me. I am further aware that there may be a need for further follow-up testing depending on the results of my test.

8. I understand that there may be incidental findings outside the original purpose for which the test was conducted, I hereby consent to:
   8.1 PLS in-house genomic testing: not being notified of any incidental findings
   8.2 Genomic testing not performed by PLS: to be informed of incidental findings, depending on the policy of the external laboratory

9. I understand and acknowledge that the test results will not be disclosed to any third parties (including family members) without my prior consent save for those who are involved in my medical care which could include clinicians/geneticists attending to me.

10. I understand that any remaining excess sample after the testing has been completed may be retained anonymously for use by Parkway Laboratory Services Ltd for validation, process development, and/or quality control studies. I am aware that the excess sample will have a retention period of 116 years and that the sample can either be stored in the main laboratory premises or at an off-site storage facility.

11. I consent to any further use and management of my/the patient's genetic information (*including the use and management of the genetic information after death, where possible*) and any further, management, and disposal of my/the patient's samples (*including the use, management and disposal of the samples after death, where possible*).

12. I hereby agree to release Parkway Laboratory Services Ltd from all liability, including that arising out of and or in connection with (i) any non-receipt of test results due to non-payment for test request or (ii) any

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injury, loss of profits, indirect, consequential or special damages, either physical or mental which might be sustained by me/my child/donor as a result of the test and/or the test results.

13. I confirm that I have been given sufficient time to consider the advice given to me and have had adequate opportunity to ask questions during the pre-test counselling.

14. The foregoing was translated to me in _____ (Language/Dialect) by _____. (Name and Signature of Translator)

Full Name of Patient (Block Letters)

_____

Full Name of Parent/Guardian* (If Patient is Under 21 years old) (Block Letters)

_____

Full Name of Patient's Donee/Court-Appointed Deputy*
(If Patient lacks Mental Capacity[1]) (Block Letters)

_____

NRIC / Passport No. **Signature / Right Thumb Print**

_____ _____

CLINICIAN'S ACKNOWLEDGEMENT

1. I confirm that I have explained the nature and purpose of the genomic testing that I have requested for, provided the patient with adequate information on the benefits, limitations, material risks and implications of the genome testing, and addressed the other concerns that this patient had raised.
2. I confirm that I have documented the advice which I had given to the abovenamed patient/parent/guardian/donee/court-appointed deputy*.
3. I shall provide opportunities for post-test genetic counselling when the test results are made available.

_____	_____	_____
Name of Doctor	Signature of Doctor	Date

[1] Under the Mental Capacity Act (Cap 177A)
**Delete where applicable*