المختبر المرجعي الوطني
National Reference Laboratory
Brought to you by M42

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Patient Consent for Hereditary Genetic Testing

1. **Purpose of the Test**
   Genetic testing is performed to identify inherited (germline) changes in your DNA/RNA that may:
   a. Confirm or rule out a suspected diagnosis.
   b. Assess risk for certain genetic conditions.
   c. Guide medical management, treatment, and surveillance.
   d. Inform family members about potential genetic risks
2. **Test Procedure**
   a. Testing will be performed on blood, saliva, or tissue sample collected as part of your medical care.
   b. Genetic material, including nucleic acid (e.g., DNA and/or RNA), will be extracted and/or obtained from your sample(s), and the testing will be performed on this genetic material in accordance with NRL's standard operating procedures. The result will be linked to your electronic health record. The testing process may also generate additional data and information. The genetic and other submitted material may be retained and used for future testing ordered by your health care provider or to improve tests and testing technologies.
3. **Potential Risks & Limitations**
   a. The test may not detect all genetic changes relevant to your condition.
   b. A negative result does not guarantee the absence of disease risk.
   c. A positive result may indicate an increased risk of disease or predisposition but does not predict certainty of disease.
   d. A variant of uncertain significance (VUS) may be reported when current knowledge does not allow a clear interpretation.
   e. Rare technical errors may occur.
   f. Inherited results may have implications for other family members.
4. **Incidental and Secondary Findings**
   a. For broad tests such as Whole Exome/Genome Sequencing, there is a possibility of discovering unrelated but medically important findings (e.g., hereditary cancer or cardiac risk).
   b. Please indicate your preference:
      ☐ I wish to receive information on incidental/secondary findings.
      ☐ I do not wish to receive incidental/secondary findings.
5. **Confidentiality & Data Protection**
   a. Your results and personal information will be kept confidential and shared only with authorized healthcare professionals involved in your care.
   b. Your genetic data will be handled in compliance with Abu Dhabi Department of Health, UAE Ministry of Health and Prevention, and federal data protection laws. Your data and extracted genomic material will be retained according to the approved retention list in line with local regulation (DOH Policy on Genomics) and UAE Law (Federal Decree Law No. (49) of 2023 Regulating the Use of the Human Genome)
   c. De-identified data may be used for medical research, quality improvement, or test development in accordance with UAE regulations.
6. **Voluntary Participation & Right to Withdraw**
   a. Your participation in this test is voluntary. Should you choose not to proceed with your testing, or should you choose to withdraw your consent at any time please contact your healthcare provider.
   b. You may withdraw consent at any time before the test is performed.
   c. You may request for your genomic material DNA and/or RNA to be destroyed 60 days after completion of the test by contacting your healthcare professional. Your healthcare professional must explain the consequences of destruction of your genetic material for purposes of re-testing.
7. **Patient Consent Declaration:** My signature below acknowledges my voluntary participation in this test. I had the opportunity to ask questions and received satisfactory answers.

Patient Signature	Date (dd-mm-yyyy)
Patient Printed Name (*Last, First, Middle*)	Birth Date (dd-mm-yyyy)

Checking the "Opt out of DNA storage" box below means that my samples will be destroyed upon completion of this test and will not be used for anonymized research studies or quality assurance performed in the laboratory. Should reanalysis be requested in the future, new sample(s) will be required. If the box below is not checked, opt in will be assumed.

☐ Opt out of DNA storage.

8. **Physician or Counselor's Statement:** I have explained genetic testing (including the risks, benefits, and alternatives) to this individual. I have addressed the limitations outlined above, and I have answered this person's questions to the best of my ability.

Physician or Counselor Signature	Date (dd-mm-yyyy)
Physician or Counselor Printed Name (*Last, First, Middle*)	