

**Form B**  
**Patient Consent**

## Chromosome Microarray Analysis

I have discussed the Microarray test with my Doctor.

I have received the Patient Information Pamphlet.

I understand that this is a specialised genetic test that may help explain the medical condition that I/my child have.

### Results

I understand that in some cases the findings of the test may be inconclusive and parent's blood/DNA may be requested to help clarify results.

I understand that results are interpreted according to current medical knowledge and that future findings could change how results are interpreted. Also, that the test may provide unexpected findings that could be clinically significant.

I give consent for my (or my child's) sample to be used for education or test validation after personal identification is removed. I can withdraw my consent at any time by contacting Molecular Genetics, Tel: 9317 0999.

Patient Name .....

Date of Birth    \_\_ / \_\_ / \_\_

Parent / Guardian .....

Signature

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

Please attach both Form A (Clinical Submission) and  
Form B (Patient Consent) to the laboratory request form.