



Affix patient sticker

Patient agreement for Prenatal Microarray Diagnostic Testing

Name of proposed procedure: **Prenatal Microarray Diagnostic Testing**

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits:

- to help explain the ultrasound scan findings/detect gains or losses in chromosomal material that have arisen from familial rearrangements
- to give more precise information about what this means for the baby

Serious or frequently occurring risks:

- not all small chromosome changes can be detected
- tiny changes in individual genes cannot be detected
- results can be difficult to interpret and a blood sample from both parents is needed for comparison
- changes called 'variants of unknown significance' may be found. There is not enough information to know if these are significant. Where there is uncertainty, these variants will not be reported.
- the test may show a finding which is not related to the ultrasound findings but which may have implications for the future health of the baby and possibly for other family members.
- The patient has been given the **Prenatal Microarray** leaflet

Signed: _____ Date: _____

Name (PRINT) _____

Job Title: _____

Contact details (if patient wishes to discuss options later) _____

Statement of Patient

I have had a chance to read the **Prenatal Microarray** leaflet.

I agree to the procedure described on this form.

I understand that where tissue material or a specimen is obtained then it may be used anonymously for teaching, research or public health monitoring.

Patient's signature: _____

Date: _____

Name (PRINT): _____

A witness should sign below if the patient is unable to sign but has indicated consent.

Signed: _____ Date: _____

Name (PRINT):

Relationship to patient: _____