BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

Addressograph

Predictive Genomic Testing Consent

All fields must be completed LEGIBLY (patient demographics may be addressographed**).**

Patient Name(last, first) _____ **PHN**_____

Date of Birth(d/m/y)_____**Sex M F BCCA No.**_____

Requesting Physician_____**MSC #**_____**Phone**_____**FAX**_____

Originating Hospital:_____**Path. Specimen #:** _____

Instructions to the submitting Physician

Please fax this form and appropriate test request form to the BCCA lab at

604-877-6178.

This form is for BCCA only, NOT to be used for any other Laboratory

Patient consent for tissue acquisition

I,_____instruct the BCCA laboratory to release the requested tissue block, DNA or other sample material to the testing facility for use for testing as indicated on the test request form that accompanies this consent. Although it is unlikely that the DNA sample or tumour in the block(s) would be exhausted (meaning that the entire biopsy is destroyed in the process of extracting the DNA required) I understand that if this does occur, further testing may not be possible on the sample(s) submitted. I understand this test will not require any further surgery or biopsy.

I agree that PHSA and BCCA are not responsible or hold any liability associated with the retention and handling of any sample materials by the testing facility.

I agree to provision of my personal information (name, date of birth, gender, Personal Healthcare Number, phone number and a copy of the pathology report) to the testing facility as required to process this request. I understand that this information may be retained at the testing site for a period of time as indicated in the test request form that accompanies this consent form. All the questions I have asked regarding the nature of the information that will be disclosed have been answered in a satisfactory manner and I consent to the release of the information to care providers who will be testing the sample/tissue.

Subject's Signature…… Date…….

Witness' Signature…… Date…….

Signature of Physician…… Date…….

To be completed by the interpreter:

I, _____ have interpreted consent information faithfully and accurately.

Dated:_____

Revised 6th June 2016