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| **HOSPITAL AUTHORITY****CONSENT FORM FOR****BRCA1/2 MUTATION TEST FOR BREAST CANCER PATIENTS** |  |  |
| Admission/Clinic No.: |  | ID No.: |  |  |
| Name: |  |  |
| (in Chinese) |  |  |
| Date of birth: |  | Sex: |  | Dept: |  |  |
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1. I have read the information leaflet on *“BRCA1/2 Mutation Test for Breast Cancer Patients”* given by the healthcare staff, and had relevant discussion with them.
2. I understand that the results and interpretations in the test report are based on the current technology and knowledge. Future advances may provide further insight and possibly lead to a different understanding of the results.
3. I understand that the possible genetic result(s) include the following:
4. **Disease‑causingmutation(s) was/were found**: if disease‑causing mutation(s) was/were detected, it is highly probable that I am affected by hereditary breast and ovarian cancer syndrome.
5. **No disease‑causing mutation was found**: this indicates that the molecular diagnosis of the gene being investigated was not confirmed or substantiated. It may be due to the absence of disease‑causing mutations in the blood, or due to limitations of current techniques or other unknown factor(s). However, the result does not totally exclude the possibility of BRCA1/2 gene mutations in my blood sample.
6. **Variant(s) of uncertain clinical significance (VUS)**: a mutation was found but whether this mutation will result in any disease or is just a benign polymorphism is uncertain with the latest medical genetic knowledge. Polymorphism means the mutation is present in more than 1% of the general population that likely does not have harmful effects on health. When “VUS” was detected, genetic counselling and further genetic studies may be indicated. Nevertheless, a definitive conclusion may still not be made after the additional work up.
7. I understand that the test result may potentially affect myself and/or my family members in terms of insurance applications, psychological or social issues.
8. I give consent to the Hospital Authority to perform the blood BRCA1/2 germline mutation test for breast cancer treatment.
9. If the test results cannot be released to me due to my incapacity or death, the test results may be released to a nominated individual upon request within 3 months after the test results are available.

Name and contact of the nominated individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The doctor (who signs this Form) has fully explained the nature, effect/benefits and the potential risks/implications of the mutation test to me and my family.

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| Signature of Patient |  | Signature of Patient’s parent or guardian/Patient’s legal guardian appointed under the Mental Health Ordinance |
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| Signature of Doctor |  | Name of Doctor in Block Letters and Staff Rank |
|  |  |  |
| Signature of Witness |  | Name of Witness in Block Letters(and Staff Rank if applicable) |
|  |  |  |
| Signature Date |  |  |