

CONSENT TO BE TESTED FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES

It has been recommended to me by my physician that I have blood drawn for the purpose of having the blood tested for the presence of antibodies to the HIV virus.

HIV virus means the human immune deficiency virus, identified as the causative agent of Acquired Immune Deficiency Syndrome or AIDS. Persons with this virus can get AIDS and may transmit the virus to others. Evidence to date suggests that transmission of the virus takes place only through sexual contact, exposure to blood and other body fluids, and during pregnancy. However, there is much that is not known about this virus and its potential for transmission of and for causing AIDS.

- A. Risk. I understand that if I sign this form the test for HIV antibodies will be performed and that it involves needle pricks, the drawing of blood, and possible bruising.
- B. Purpose. I understand that the purpose of the test is to inform myself and those treating me of the possible presence of the virus, and to inform those persons exposed to my blood products or bodily fluids whether they have been exposed to the HIV antigen.
- C. Consequences. My physician has explained to me the consequences of a positive test result. I understand the significance of the test results and that post-test counseling will be made available to me in the event of a positive test result.
- D. Disclosure: I understand that the test result will become part of my medical record and will be available only to persons having access to such records and to members of the healthcare team involved in my care.
- E. Consent: The doctor/designee has explained to my satisfaction the risks, benefits, significance, and implication of the test and the test results and answered my questions.

I hereby voluntarily consent to having the blood sample drawn and for the blood to be tested for the presence of antibodies to HIV.

Patient Signature: _____ Date: _____

Witness: _____

Guardian or other person authorized to give consent: _____

Physician Signature: _____

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