WRITTEN CONSENT FOR PERINATAL HIV ANTIBODY TESTING

PATIENT’S NAME: ________________________________

The Illinois HIV Prevention Act mandates that all women in the state of Illinois must be counseled and offered and HIV test during pregnancy, with the test result or a notation of test refusal documented in the prenatal record, the labor and delivery record and the newborn pediatric record. The HIV test is a test to determine the presence of the antibody to HIV, the agent that causes AIDS. If you refuse to allow your physician to test for HIV during pregnancy, or you are tested by your physician but you arrive at the hospital for delivery with no documented HIV status, the law requires that the hospital test you so the antiretroviral therapy can be administered to significantly reduce the risk of HIV transmission to your child. Additionally, if the hospital is unable to verify that you have been tested for HIV and obtain the results of the test from your physician at the time of delivery, the hospital will be required to test your newborn for HIV, unless you refuse in writing to allow testing. The purpose of this form, therefore, is to obtain your consent to be tested for HIV, and your consent to release your identity and the results of the test to any hospital at which you present for delivery or other healthcare treatment.

I am giving my permission for a blood test in order to detect whether I have antibodies to the HIV virus or any other identified causative agent of AIDS in my blood. I understand the results will be utilized for the purposes of my medical care and treatment.

I understand that the test is performed by withdrawing a sample of my blood and conducting laboratory tests to determine the presence of antibodies to HIV. I understand that the results of the blood tests considered to be positive will be reported to the Illinois Department of Public Health.

I further understand that a positive result does not mean I have AIDS, but that my blood has been exposed to the AIDS virus, and antibodies to that virus are present in my blood. I understand that counseling concerning AIDS will be offered to me if my test results are found to be positive.

I have been informed and understand that the test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result), or that the test may fail to detect that a person has antibodies to the virus when the person does, in fact, have these antibodies (a false negative result).

I understand that my test results will be released to my physicians and other healthcare providers providing my care. This includes any hospital at which I present for delivery or other healthcare treatment. In addition, I understand that the law allows my identity and test results to be disclosed to specific persons, such as the physicians and healthcare providers involved in the use of any donated organs or tissue, and the Illinois Department of Public Health, healthcare facility staff committees, and research studies (without name). I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time, prior to the completion of the laboratory tests.

____________ I agree to have my blood tested for HIV infection
____________ I refuse HIV testing at this time. I understand I can request this test later
________________ Signature of Patient or Legally Authorized Representative
_________________________ Date