

**HIV RAPID DIAGNOSTIC TEST CONSENT**  
**San Francisco General Hospital Medical Center - Clinical Laboratories**  
**Maternal Child Health – 6C / Birth Center**

<b>Ordering Clinician:</b>			<b>NAME</b>
Name	Title	CHN ID#	<b>DOB</b>
			<b>MRN</b>
<b>Attending MD:</b>			<b>ICD9 :</b> <input type="checkbox"/> <b>v65.44</b> HIV Counseling
<input type="checkbox"/> Check if same as Ordering Clinician (& skip to next box).			<input type="checkbox"/> <b>v15.85</b> Exposure to potentially hazardous body fluids
Name	Title	CHN ID#	Specimen collected by: _____ Date: _____ Time: _____
Order Date:	Unit: <b>6C - Labor and Delivery</b>	Service:	

- I have received a copy of Rapid HIV Testing on Labor and Delivery Information Sheet.
- I understand that I am being tested for infection with HIV, the virus that causes AIDS.
- I understand that the rapid HIV test gives a preliminary positive result and that a 2<sup>nd</sup> type of test must be done before I can know if I really have HIV. The results of this 2<sup>nd</sup> (confirmatory) test are usually ready within one week. If I have already been discharged from the hospital, I will be given an appointment to get my final test result.
- I understand that if my rapid test result is positive, I will be given medicine and my baby will be given medicine to help prevent HIV in my baby, *even if I don't want to know the HIV test results right away.*
- If my result is positive, I will be referred for specialty care. My healthcare provider will talk with me about the options available to help me let my sexual and/or needle-sharing partner(s) know that they may have been exposed to HIV and should seek testing. If I choose not to inform my partners, my doctor may inform them without my consent, but may not give my name and must first attempt to let me know of his/her plan to inform them. Any other release of my results will be governed by existing law, regulations, and/or facility policy.
- Results of my test will be included in my medical record.
- If I miss my follow-up appointment, I consent to be contacted by hospital staff. My preference for contact is:  phone \_\_\_\_\_  mail to \_\_\_\_\_  visit at \_\_\_\_\_
- Please choose one of the following options and initial your preference:  
 \_\_\_\_\_ I want to be told the rapid HIV test result as soon as the result is available, even during labor.  
 \_\_\_\_\_ I do not want to be told the rapid HIV test result until after I give birth.

My questions about the HIV test were answered after discussing all of the above. My health care provider has told me what a negative or positive test result means and the reasons for getting tested. I agree to be tested for HIV and for medication to be given to me and to my infant if my rapid test is positive.

<b>Patient/Proxy*</b>		
<b>Name (print):</b> _____	<b>Signature:</b> _____	<b>Date:</b> _____
*If pt is unable to consent herself, explain why: _____; have the patient's proxy print & sign his/her own name above, and note relationship to the pt: <input type="checkbox"/> parent <input type="checkbox"/> guardian <input type="checkbox"/> other _____		
<b>Clinician/Counselor obtaining consent:</b>		
<b>Name (print):</b> _____	<b>Signature:</b> _____	<b>Date:</b> _____
<b>If an Interpreter was used, or an employee Witness was required:</b> <span style="float: right;"><input type="checkbox"/> Interpreter <input type="checkbox"/> Witness</span>		
<b>Name (print):</b> _____	<b>Signature:</b> _____	<b>Date:</b> _____