

Medical Record Number

Patient Name

Addressograph or Label

L99999

CONSENT FOR RAPID HIV TESTING OF PREGNANT PATIENTS

The following information concerns rapid Human Immunodeficiency Virus (HIV) testing on Labor and Delivery.

- I understand that I am being testing for infection with HIV, the virus that caused AIDS.
- I have been provided the *LPCH Information form on for rapid HIV testing of pregnant patients*. I understand the following:
 - HIV is a disease that weakens the immune system, making it hard for the body to fight infections.
 - HIV is primarily spread by having unprotected sex or sharing needles with an HIV infected person. You can protect yourself from HIV by using a latex/polyurethane condom (male or female) when you have sex, even if you are pregnant and by not sharing needles for injecting drugs, steroids, vitamins, tattooing or piercing.
 - A pregnant woman who is HIV infected or who as AIDS can pass HIV to her baby during pregnancy, at delivery, and while breastfeeding.
 - An HIV test will help you and your baby by alerting you to the need for treatment if your HIV test is positive.
 - If you are infected with HIV, treatment with appropriate medication can reduce your chances of giving HIV to your baby.
- I understand the purpose of the HIV testing and that my blood will be tested for HIV unless I decline. I understand that I have the right to refuse this routine test.
- I understand that additional testing is required to confirm a positive test result, and that if I have been discharged from the hospital, I will be given an appointment to get my final test result.
- If I miss my follow-up appointment, I consent to be contacted by the hospital staff. My preference for contact is:
 - phone _____
 - mail _____
 - visit at _____
- I understand that if my test result is positive, I will be referred for special care.
- I understand that results of my test will be included in the medical record and can be shared with my treatment providers. I also understand that positive test results will be reported to the local health officer. Otherwise, I understand that, unless required by law, my written consent will be required for the test results to be shared with other individuals.
- I may call the California HIV/AIDS Hotline at 1-800-367-2437 for HIV referral and consultation resources.

After reading the information provided above and have had all my questions answered about HIV testing, I hereby agree to the following,

I agree to be tested for HIV at this time and authorize subsequent treatment for me and my baby in order to decrease the risk of HIV transmission to my baby.

I do not agree to be tested for HIV at this time.

DATE	Patient/Parent/Properly Designated Representative Signature:
	Nature of Relationship to Patient
	Witness/Name of person obtaining consent Signature: