



KANSAS CITY WOMEN'S CLINIC

KCWC: A tradition of excellence since 1953

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Pt. Name: _____ Acct # _____

CONSENT TO TESTING FOR HIV ANTIBODIES

With concern for the well-being of our patients and their infants, KCWC supports the recommendations of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in encouraging testing during pregnancy for the virus that causes acquired immune deficiency syndrome (AIDS). This virus is the human immunodeficiency virus (HIV). These organizations have issued the following joint statement, "The HIV/AIDS epidemic is increasing in women of childbearing age and spreading beyond previously-defined risk groups and geographic areas." Studies demonstrate clear medical benefits in knowing the HIV status of pregnant women. Treatment can significantly reduce the likelihood of HIV transmission from mother to infant. You are being requested to undergo testing that would indicate the presence of HIV antibodies in your blood.

- I understand that positive results from this test usually indicate these antibodies are present. False positive results can occur. If positive, this test will be repeated and an even more specific test done. The combination of these tests reduce the possibility of a false positive. If I am infected with HIV this means that I can infect other people with HIV, including infecting a baby during pregnancy or birth, or through breast feeding. Positive test results do not mean that I have AIDS nor can they predict whether I will develop AIDS in the future. Only confirmed results will be reported to me and to the appropriate state health authority as required by law.
- I understand that a negative test result does not conclusively exclude the possibility that I am infected with HIV. If I have any questions whether or not I may have been exposed to HIV, it is recommended that I be re-tested in six weeks and again in six months.
- I understand that Kansas City Women's Clinic will take precautions to protect the confidentiality of these ANTIBODY test results. There will be no disclosure to any unauthorized third party without my express written consent and release, other than as required by law.
- I understand, however, that the results of this test will be recorded in my medical record and that the results will be released to my primary care physician and/or persons to whom I have authorized the release of HIV information.
- I understand and agree that the results may be disclosed as necessary to assure appropriate follow-up testing and care of the health care worker exposed to my blood and other body fluids.

After the test results are obtained, my physician will discuss these matters with me and, if necessary, refer me for appropriate medical, psychological, and social counseling.

I have received information about the cause and methods of transmission of HIV; testing methods; meaning of test results; and type of behavior necessary to reduce the risk of exposure to HIV.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read the above and have had the opportunity to discuss this information and to ask questions. I am aware of the test's limitations and the potential consequences of positive and negative test results. **I understand that the cost of this test may not be covered by my insurance.**

I do not want the test.

Patient Signature

Today's Date