CONSENT FOR HIV TESTING AFTER A BLOOD OR BODY FLUID EXCHANGE

In the course of medical care and treatment, healthcare workers may be accidentally exposed to a patient’s blood or body fluids (through needle sticks, blood splatters, etc.).

Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposure of this type.

When a healthcare worker is exposed to a patient’s blood or body fluids, the patient must be tested for the HIV antibody or other communicable diseases in order to determine whether an actual exposure has occurred. This information is necessary so that the healthcare worker can receive appropriate counseling and medical treatment.

I understand and agree that, in the event a healthcare worker is exposed to my blood or body fluids during my admission, my blood will be tested at no cost to me, using a special coded system, for the HIV antibody and other communicable diseases.

If such exposure occurs, I am aware and do consent that I will undergo any necessary testing and will receive additional information about the HIV antibody test at that time. The results of this test may improve the course of my medical treatment and will not be prejudice my patient relationship with the office.

Patient Name: (Please Print)  _____________________________________________________

Patient Signature: ___________________________ Date: ____________________

Witness Signature: ___________________________ Date: ____________________

Physician Only: I confirm with my signature that I have made time available to discuss with the above-named patient the risks, potential complications, and intended benefits of surgery. The patient has had the opportunity to ask any questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested to perform surgery on him/her.

Physician signature: ___________________________ Date: ____________________

Our patients are offered a copy of any form they sign.