Counsel for HIV Antibody Blood Test

____
Use patient imprint

____
Name

I acknowledge that ____ has counseled me
(Name of physician or other provider)
and provided me with:

A. Information about how HIV is spread
B. The benefits of voluntary testing
C. The benefits of knowing if I have the HIV virus or not
D. The treatments available to me and my unborn child should I test positive and
E. My right to refuse the test and not be denied treatment

☐ I have agreed to be tested for HIV infection.

☐ I have decided not to be tested for HIV infection.

This form will be kept as part of my medical record.

____________________________ ____________________________
Signature of Patient Date

____
Signature of Witness