Pacific Reproductive Services

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INFORMED CONSENT FOR THE HUMAN IMMUNO-DEFICIENCY VIRUS BLOOD TEST

I have been informed that a sample of my blood will be tested in order to detect whether or not I have been infected by the Human Immuno-Deficiency Virus, which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS).

I have been informed that the test results may rarely indicate that a person has antibodies to the virus when the person is not infected (false positive) or fail to detect that a person has antibodies to the virus when the person is infected (false negative). I understand that in order to diagnose AIDS, other means must be used in conjunction with this blood test.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternative tests, I may ask my health care provider those questions before I decide to consent to the blood test. I understand that the results of this blood test will be placed in my medical record and available to those health care providers responsible for my care and treatment.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and use of results and have had all of my questions answered.

Date: _____ _____
Signature

_____
Printed Name