HIV Test Consent

Informed consent. The counsellor fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

COUNSELLOR NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

TEST

DATE

PRE-TEST COUNSELLING BY

A blood sample is tested for HIV. You will receive pre-test and post-test counselling. Your result is confidential and will be given only to you, or to someone you authorise, except where the law requires disclosure.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Brief pain or bruising when blood is drawn
- A reactive screening result needs confirmatory testing; a negative result may not cover very recent exposure (window period)
- Emotional distress; counselling and support are available

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Declining the test
- Testing at a government ICTC, free of charge

Who may receive the result?

◯ Only me ◯ Me and my treating doctor ◯ Me and the person named below

AUTHORISED PERSON (IF ANY)

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The counsellor has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Counsellor

SIGNATURE

PRINTED NAME

DATE