

HIV screening

- The state of Texas now mandates HIV screening for all pregnant women *unless* the patient specifically declines in writing (see below).
- The HIV screening test will be done at your first OB visit and again during your third trimester.
- If you do not decline HIV screening, here are some things you should know:
- This test is not run anonymously but the doctors will take precautions to protect confidentiality of these test results. There will be no disclosure to any unauthorized third party without expression in written consent.
- The test is NOT diagnostic for AIDS and the meaning of a positive test is still under investigation.
- Positive test results indicate the presence of ANTIBODIES in your blood which react with the HIV antigen. Positive results do not conclusively indicate whether or not the virus is present in your blood, neither does a positive result mean that you have AIDS. A positive test result also does not predict whether or not you could develop AIDS in the future.
- A negative test result does not conclusively exclude the possibility of infection with HIV virus.
- All positive test results will be confirmed by performing a second confirmatory test.
- The test result may be reported to the Public Health Authorities as required by law.
- The results will be recorded in your medical record and will be released to persons or entities to which you authorize the release of your medical record.
- A waiver of the privilege of confidentiality and privacy of your medical records in order to gain insurance reimbursement means that the results of the test will be disclosed.
- The results may be disclosed as necessary to assure appropriate follow up testing and care of any health care worker exposed to your blood or bodily fluids.
- After the test results are obtained, your physician or staff will discuss the results with you.

After reviewing this form, please feel free to discuss this with your doctor if you have further questions.

_____ (initial) **Please initial here**, stating that you received and read this form.

If you do not sign below, you are agreeing to have HIV testing performed.

If you **DECLINE** HIV testing, please sign below:

I, (patient name) _____ have reviewed the above information and **DECLINE** to have HIV testing performed as part of my routine OB care.

Signature _____

Date _____