Human Immunodeficiency Virus (HIV) Antibody/Antigen Test

CONSENT FORM HIV Ag/Ab Combo HIV Test

The HIV Ag/Ab combo assay is a test for detection of human immunodeficiency virus (HIV). This test looks for both HIV antigens and antibodies that may have developed due to infection with HIV.

I understand a Combo Test will be performed which will use a specimen from a drop of blood from my finger which may be followed by a second test, done from a drop of blood from my finger to confirm an antibody positive test result on the combo test. If there is an antigen positive result on the combo test the confirmation test will use a specimen of blood drawn from my arm.

I understand I will receive a test result today.

If I receive a Negative Test result it means that it is extremely unlikely I am infected with HIV.

If I receive a Preliminary Positive test result, it means there is a very good possibility that I am infected with HIV. It also means I would need additional blood tests to confirm the HIV positive result. If a drop of blood is taken from my finger to perform a second rapid test for antibodies to the HIV viral proteins, I will receive the results in about 20 minutes. This is the best way of making sure the information given to me is accurate. If blood is drawn from my arm to confirm the antigen positive result I will not receive the results for a few days and will be referred to a physician.

I understand I will test confidentially, which means I will sign my name and provide my address and telephone number on this form. This is the best way for me to enter a treatment program, if necessary, and to learn of other services.

A coded number will be assigned and used to identify me. The coded number will be placed on this consent form and on all the testing materials. If a confirmatory test is necessary the same coded number will be placed on the tube of blood. All records in this testing program are maintained as confidential and kept under lock and key.

I understand that if I receive a second positive test result, it will be reported to the New Jersey State Department of Health as required by law. Any other release of this information will require my written consent, a court order, or a subpoena.

I have read or someone has read this form to me. A counselor has answered all of my questions and I have decided to test for HIV. I will give my permission to test by signing the form below.

_____ _____

(Signature of Witness) (Signature of Client or Guardian)

_____ _____

(Coded Number) (Client's Street Address)

_____ _____

(Date) (City, State and Zip Code)

_____

(Telephone Number)

GLOUCESTER COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
HIV QUESTIONAIRE

ID NUMBER_____

THIS TEST IS FREE **PLEASE PRINT**

NAME:_____ AGE:_____ BIRTHDATE:_____ RACE:_____

ADDRESS:_____

TOWN:_____ COUNTY:_____ STATE:_____ ZIP:_____

YEARS OF EDUCATION_____ NUMBER OF MARRIAGES IN LAST 10 YEARS_____

MY SEXUAL PARTNERS ARE: MALE FEMALE BOTH (PLEASE CIRCLE)

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH (Y) FOR YES OR (N) FOR NO

Are you pregnant?_____

Have you ever used IV drugs?_____(b) Have you ever shared needles/works?_____

Do you have a bleeding disorder (hemophilia)?_____(c) Have you ever had a blood transfusion?____(d)

Are you sexually active?_____ How many sexual partners have you ever had?_____ the last 3 months?_____

Have you ever had sex with a man who is bisexual?_____(f)

Have you ever had sex with an IV drug user?_____(g)

Have you ever had: tattoo, acupuncture, or body piercing (including ears) or used steroids?_____(h)

Have you ever had sex with someone who has a bleeding disorder (hemophilia)?_____(i)

Have you ever exchanged sex for money or drugs?_____(j)

Have any of your sexual partners ever had transfusions?_____(k)

Are any of your sexual partners a prostitute or test positive for HIV/AIDS?_____(l)

Have you ever had sex while under the influence of non-injection drugs(alcohol, cocaine, marijuana, other)?___(m)

Are you a health care worker (also EMT/ambulance, etc)?_____(n)

Was your mother at risk for HIV or AIDS?_____(o)

Have you ever been the victim of a sexual assault or rape?_____(r)

Have you ever had: Hepatitis, Tuberculosis, or Sexually Transmitted Diseases?_____(s)

Have you ever been tested for HIV before?_____ When?_____ Results:_____

Does the counselor recommend retesting?_____ When?_____ (COMPLETED BY COUNSELOR)