Maine Medical Center

SOURCE PATIENT HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST CONSENT FORM

147600

PATIENT NAME LABEL

Appendix K

I. OCCUPATIONAL EXPOSURE AND HIV

HIV has been identified as the virus that causes Acquired Immune Deficiency Syndrome, commonly known as AIDS. HIV decreases an individual's ability to fight off diseases such as those caused by infections, viruses, and cancer. Untreated HIV can lead to significant illness and premature death.

The virus can be transmitted by direct exposure to the blood and/or body fluids of an individual who has the virus. The exposure can occur from sex or by contact with blood and/or body fluids such as with a used needle. Whenever an individual has this type of exposure to the blood and/or body fluids of another person who has the virus, there is a risk of becoming infected with the virus.

I understand that a health care provider, emergency response provider or other individual has been accidentally exposed to my blood and/or body fluid. I further understand that the Occupational Safety and Health Act ("OSHA") requires Maine Medical Center to attempt to find out if I have an infection that could be transmitted by my blood and/or body fluids. In order to treat the individual who was exposed, it is important to know whether or not I have the Human Immunodeficiency Virus ("HIV").

II. NATURE OF THE TEST

I understand a sample of my blood will be tested for HIV infection using the Multispot HIV-1/HIV-2 Rapid test or the Chemiluminescent test. The Rapid test will be used in most cases to allow for prompt medical management of the exposed individual. Both tests detect antibodies to the Human Immunodeficiency Virus. Other tests, such as testing for HIV antigens and polymerase chain reaction ("PCR"), also may be performed on the blood sample. Any positive test results are then retested with a different test, the Western Blot Assay. I further understand that such testing may be performed on current blood samples, if available, in the Maine Medical Center's laboratory. HIV testing and pre-test and post-test counseling shall be provided to me at no charge.

III. TEST RELIABILITY

I understand that a negative test means that the antibodies to HIV were not found in my blood sample. This means I am not infected with HIV at this time. A false-negative test is rare but could occur if I recently was exposed to the virus and my body has not produced enough antibodies to be detected yet.

A positive test usually means that I have been exposed to HIV in the past and I am infected with the virus. A false positive test means the test is positive, but I do not have HIV infection. There are a number of other tests that a physician may use to evaluate false-positive test results if appropriate.

IV. DISCLOSURE OF TEST RESULTS

I understand and agree that my test results will be shared with Employee Health Services, Emergency Department, or Epidemiology & Infection Prevention so that they may counsel the individual and to my designated medical care provider so that they may offer the test results to me. I am aware that the test results will not become part of my medical record but instead will be maintained in a separate file in Maine Medical Center's Employee Health Services, Emergency Department and/or Health Information Management (Medical Records) department. I further understand that I may decide to have the test results entered into my medical chart and may decide who else may have access to such results except when required by law to be reported to the Maine Department of Health & Human Services, Maine CDC. Additionally I understand that such information may be disclosed to MMC personnel for quality assurance, risk management and peer review purposes to the extent necessary to carry out the usual and customary activities related to the delivery of healthcare.

V. PURPOSE AND BENEFITS

I understand that this test is being performed to determine if there is a potential health risk for the individual exposed to my blood and/or body fluid. I further understand that learning whether I am infected with the HIV virus may result in earlier treatment, assist with my future health care and minimize the transmission of the virus to others. I have been informed that face-to-face counseling is available to me both prior to and after the HIV tests are completed. I understand that I may waive face-to-face counseling and further agree to receive my test results and post-test counseling either by letter and/or telephone call from my primary care physician or designated health care provider. Such post-test counseling shall include: (i) the test results and their reliability and significance; (ii) the social and emotional consequences of the information; (iii) preventive practices and risk reduction plans; and (iv) referrals for medical care and support services as appropriate. Any applicable post-test counseling information will be sent to the individual I designate to receive my HIV results.

VI. FORESEEABLE RISKS

I understand that in order to be tested for the HIV virus, I must undergo a blood test. The risk of this blood test is minimal, but it will include having a needle puncture and occasional bruising of the skin may occur. I further understand that there may be medical, psychological and social issues associated with obtaining an HIV test and its results, especially a positive test results. A positive test result can cause considerable anxiety. Individuals with positive test results may be subject to discrimination if they inform others of the test results. There is a slight risk of an inaccurate test result.

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VII. CONSENT

I acknowledge that by signing this form I either have received face-to-face pre-test counseling or have elected to waive such counseling. I understand what a positive or negative HIV result means and all of my questions about HIV testing have been answered to my satisfaction.

I wish to have my test results sent to:

☐ **My Physician or designated Healthcare Provider:**

Name: _____

Address: _____

_____

☐ **I wish to be informed of the results by my Physician or Healthcare Provider**

☐ **I wish not to be informed of the results or receive post-test counseling unless the results are positive.**

☐ **Directly to me at the below address in an envelope marked 'confidential' with guidance to contact my physician or healthcare provider if I have questions about the results:**

My mailing address: _____

_____

☐ **I understand if the test is positive, it is mandatory that Maine Medical Center reports the result to the Maine Department of Health & Human Services, Maine CDC and I will be contacted by a clinician from the Bureau of Health and/or a physician from Maine Medical Center and will receive post-test counseling.**

☐ **I wish not to have my results:**

☐ **I understand if the test is positive, it is mandatory that Maine Medical Center reports the result to the Maine Department of Health & Human Services, Maine CDC and I will be contacted by a clinician from the Bureau of Health and/or a physician from Maine Medical Center and will be offered post test counseling.**

I hereby voluntarily consent to have my blood drawn and tested by the Maine Medical Center's laboratory, or an outside testing laboratory the hospital selects, for the presence of HIV antibodies and antigens for evidence of HIV infection. This consent is given freely.

_____ _____
Signature of Source Patient Date

_____ _____
Signature of Witness Date

If patient is a minor or is unable to otherwise give informed consent, the following must be completed.
The patient is unable to sign this consent form for themselves because:

_____

_____

_____ _____
Witness Signature of patient's representative

Date: _____ _____
Individual authorizing testing pursuant to statute