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**CONSENT FOR HIV TESTING**

Voluntary HIV testing is offered routinely to all women as part of standard gynecological care. Human immune deficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS), the disease caused by HIV are growing threats to women. It is strongly recommended that every patient have an HIV test because there are treatments available that can control HIV and reduce the chance that it be passed on to another. Although many patients feel they are not at risk for HIV, it is recommended that everyone have this test as part of their prenatal care.

**HIV TRANSMISSION AND PREVENTION**

HIV can be transmitted from person to person in blood, semen, vaginal fluids and through breast milk. About one third of the time, the virus is passed to the fetus during pregnancy. Most infected babies die within three years after birth. Because the virus can be passed across the placenta before birth, it makes no difference whether the baby is born through the vagina or by cesarean delivery-infection may already have occurred. Besides transmission from mother to baby, HIV is also spread through unprotected oral, vaginal, and anal sex with an infected partner or through infected blood, such as from sharing needles.

**HIV RESULTS**

Testing for HIV can be done by means of a blood test which is drawn along with your first prenatal profile. Some insurance companies, however, may not pay for this test as they may consider it to be routine. The cost for the HIV test is $40.00. A positive result means that a person who has been infected with HIV is eligible for treatment and other services. A negative result means there was no sign of infection, so it is likely that the person is fine. However, it can take up to three months for a recent infection to be detected by the test.

Your results will be kept confidential and a part of your medical record; only you and the staff involved in your care will know about them. Any conversation regarding your test is confidential and will not be shared with anyone else.

**I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION.**

**\_\_\_\_\_\_\_\_ I AGREE TO BE TESTED FOR HIV.**

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 **Signature of Patient Date**

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