ICON HOSPITAL – HIV INFORMED CONSENT FORM

ISO CERTIFIED 9001:2015
Gat No. 153, Tower Line Corner, Talawade Road, Triveninagar, Pune – 62
Mob.: 8149200044, 8149300044
Email: iconhospital2016@gmail.com

Patient Details

Patient Name: _____
PRN No.: __
Age: _
Sex: _
IPD No.: ___
Ward: __
Bed No.: __

---

1. INFORMED CONSENT FOR HIV TEST

I have been offered the blood test for detection of antibodies to the Human Immunodeficiency Virus (HIV) performed by an outside laboratory. HIV is the causative agent of Acquired Immune Deficiency Syndrome (AIDS).

I understand that this test may not be conclusive because a positive result means additional tests may be needed and a negative result does not necessarily eliminate consideration of AIDS. I have also been informed that the results of this test will only be released to those healthcare personnel and insurance companies providing medical care and coverage to me as allowed by Federal and State law. I understand that these test results will be a part of my medical record and will be released if I have signed an authorization for release of medical information.

I understand that not all health insurance plans will pay for HIV testing. Should my insurance company decline coverage, I understand that I will be expected to pay for it myself.

I am aware that additional information regarding HIV/AIDS and antibody testing is available at my request and therefore acknowledge that I have had the opportunity to ask any questions I have regarding this test prior to signing my consent.

---

1. I hereby give my consent for the performance of the HIV blood test and release of results as outlined above.

Name: ___
Sign: ___

Date: __
Time: ___

Witness Name: ___
Sign: ___
Date: __
Time: ___

---

2. I decline the opportunity for the HIV blood test at this time.

Name: ___
Sign: ___
Date: __
Time: ___

Witness Name: ___
Sign: ___
Date: __
Time: ___

Doctor Name: ___
Sign: ___
Date: __
Time: ___

---

2. HIV TEST CONSENT (MARATHI VERSION)

रुग्णास चिकित्सकांच्या तसेच उपचाराच्या दृष्टीने रक्ताची HIV TEST (The Human Immunodeficiency Virus) करण्याची आवश्यकता आहे.

HIV TEST द्वारे रुग्णाच्या शरीरातील HIV virus शोधण्यास मदत होते. या चाचणीद्वारे आपण पूर्ण निदान करू शकत नाही. काही पुन्हा चाचण्या करण्याची आवश्यकता लागू शकते.

रुग्णास या चाचणीचे उपयोग, मर्यादा व फायदे तसेच इन्शुरन्स कंपन्यांद्वारे होणाऱ्या भुगतानाबाबत संपूर्ण समजावून सांगितले आहे. काही कारणांमुळे ही चाचणी इन्शुरन्स कंपनीकडून कव्हर न होण्याची शक्यता आहे. परंतु ती करण्यास आम्ही संमती देत आहोत.

परिणाम मिळाल्यानंतरही ही HIV TEST गोपनीयतेने ठेवण्यात येईल.

मी खाली सही करून या चाचणीस संमती देत आहे.

नाव: ____
नाते*:* ____
सही: ____
अंगठा: ____
तारीख: _ **/** _ / __
वेळ: ____

END OF HIV CONSENT DOCUMENT