SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY

Patient Label

Date: _____

Time:_____

PRE-TEST COUNSELING

This to certify that I have done pre-test counseling of _____ on _____. I have explained in detail, the information about HIV/AIDS its modes of transmission, testing procedures, their limitations and interpretation of the result. All this information has been given in the language he/she understands and the patient is fully satisfied with my pre test counseling. I, the counselor, will do everything possible to assure that the consent of counseling session and the test result will be kept confidential.

Signature of Counselor/Clinician: _____ (Seal/Stamp of SCTIMST)

INFORMED CONSENT FORM FOR HIV TEST

Declaration by the Patient/Guardian

1. I, _____, the undersigned, hereby give my consent to undergo blood testing for HIV antibodies. My counselor has explained to me about HIV/AIDS, clarified my doubts, in the language which I understand.

2. I have been informed about HIV infection, and I am now aware of the possible outcomes of the test and their significance. I have also been informed about the limitations of the test.

3. I am aware that this test cannot be imposed on me under any circumstances without my prior permission. I understand that I have the right to refuse this test.

4. I understand that this test is being done for purely medical reasons and not for any medicolegal purposes.

5. I am hereby giving my permission to:
   - Obtain my blood sample for HIV testing
   - Perform the necessary tests
   - Generate the test result
   - Transmit the result as required for my treatment

I, hereby, have read and understood the above instructions and agree to the terms mentioned.

I understand and agree that the tests will be performed at SCTIMST.

Name of Patient: _____

Signature of Patient/Guardian: _____ Date: _____