HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST YOUTH CONSENT FORM

Name of Youth: _____ **DJJID#:** _____

Facility Name: _____ **Date of Birth:** _____

This consent form will permit _____ to test your blood for HIV antibodies.

Facility Name

Testing may be performed by various methods depending on the county or location where you get the test done. By signing the consent you are authorizing testing by one of the approved methods.

Oral (mouth). You put a pad between your cheek and gum for two to five minutes. It finds the antibodies in the blood vessels in your cheek and gum. It is sent to a lab for results and you'll receive the results in 5 to 7 days. Rapid tests. These are tests that give you results quickly. There are 2 types: blood tests and oral (mouth) tests. For the blood test, blood is taken from your finger, and you can get your results in 20 to 60 minutes. For the oral test, a pad is used to swab your gums. Results are ready in 20 minutes.

The antibody test is done by drawing, approximately 5cc's (1 teaspoon), blood from a vein in your arm. When the blood sample is drawn, you may have some discomfort at the site of the needle-stick and a small bruise may develop. Otherwise, there is no risk of physical harm.

This test is taken voluntarily. If you choose not to take the test, you will not lose any services or privileges to which you would otherwise be entitled. Test results will be confidential and <u>will only be given to you in person</u>.

For further information regarding AIDS or the HIV antibody test, please read the information issued to you. If you still have questions about this test that the nursing staff and this form have not answered, please ask to speak with the facility physician before signing this form.

I have been informed about the HIV Antibody Test. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this test procedure. I understand that if I have a positive result, the Department of Heath must be notified. I hereby give my informed consent to the HIV Antibody Test.

☐ **I consent** ☐ **I do not consent**

_____ _____

Date Signature of Youth

_____

Printed Name of Youth

_____ _____

Date Witness Signature

_____

Witness Printed Name