

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Sex:  Male  Female Hispanic/Latino:  Yes  No

**Purpose of Tests:**

- HIV: This test shows if you have antibodies to Human Immunodeficiency Virus (HIV). If there are antibodies present, this shows you have been exposed to the virus and can pass the virus on to others. The HIV test cannot determine if you have AIDS.
- Syphilis: This test shows if you have antibodies to *Treponema pallidum* (T. pallidum), the bacteria that causes syphilis.
- These tests are used as an initial screening test and additional testing may be required upon positive/reactive results to confirm diagnosis.

**Limitations:**

- HIV:
  - The testing for HIV antibodies is very sensitive, but errors may occur. A false negative result could occur if you have recently been exposed to the virus but have not yet developed antibodies. It takes at least 30-90 days for a positive test to result after a person is infected.
- Syphilis:
  - This test can't differentiate between a new and old infection because treponemal antibodies can remain positive for life after an infection. For people with a history of syphilis, a nontreponemal test should be used instead. If you have a history of syphilis, you are not a candidate for rapid testing.
  - A test done too soon after infection or drinking alcohol within 24 hours of the test can result in a false negative. It can take 14–21 days for the body's immune response to be detected by the test.

**Uses of Test:**

- Knowing your HIV and syphilis antibody results may assist your healthcare provider to determine the medical care you need. It may also help you make personal decisions, such as whether to have children and how to best avoid the risk behaviors that transmit the virus.
- If any test is reactive or positive, in accordance with Ohio Administrative Code and Ohio Department of Health reporting requirements for communicable diseases, the result will be reported to the Ohio Department of Health (ODH). Reporting is conducted for purposes of disease surveillance, case investigation, and coordination of treatment when necessary. This information is confidential and is not accessible to the public.

**Voluntary Testing:** These tests are voluntary and you do not have to take the test. You may withdraw your consent for testing at any time until your specimen is collected.

**Confidentiality:** All test results will be treated as confidential. If your screening test is positive, you are required to authorize the release of your information so that confirmatory testing may be completed. If the confirmatory test is positive, the clinic is required to report the case to Columbus Public Health (CPH) and the Ohio Department of Health (ODH) in accordance with Ohio Administrative Code and communicable disease reporting requirements. **Treatment services, if needed, will be coordinated through Columbus Public Health (CPH).** Any information reported to CPH or ODH is confidential and not accessible to the public.

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**Please select the test you want to complete today:**

**Human Immunodeficiency Virus (HIV 1/2)**

**HIV & Syphilis Combined**

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**Statement of Consent:** By signing below, I certify that: I have read and understand the above explanations of the specific testing I am requesting, including the explanation of the test, limitations of the test, what the test results mean, and reporting requirements. I have been given the opportunity to ask questions and have had them answered to my satisfaction. I understand that I am here for screening for sexually transmitted infections: HIV and/or HIV/Syphilis. I voluntarily consent to testing today by agreeing to have a sample of blood tested for the presence of antibodies. I understand I am required to complete the Risk Assessment Questionnaire fully and honestly. I understand that this screening test is confidential, but I am required to release my name, date of birth, and test result if any test is positive. I am aware that my information will be released to the state health department for tracking of reportable diseases, case investigation, and treatment if needed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_