

Testing For Sexually Transmitted Diseases

In the age of HIV/AIDS, Hepatitis, Chlamydia, Gonorrhea, Syphilis, and other Sexually Transmitted Diseases (STD's), it becomes important to make certain that any patient who is considering conception be made aware if they are carrying any STD's. Becoming pregnant with any of these diseases can result in significant medical problems to both the mother and the child.

We here at *Specialists in Reproductive Medicine & Surgery, P.A.*, (SRMS) encourage our patients be screened for STD's prior to conception. Various protocols exist that suggest repeated testing every year for the more common STD's in those patients who are undergoing conception assistance.

While it is the right of the patient to refuse testing, should a patient so refuse, SRMS cannot be held responsible for the infrequent and potentially significant adverse medical and obstetrical outcomes caused by undetected STD's.

I hereby agree to the following and understand that SRMS cannot be held responsible for my refusal to be tested on any of the items listed below:

Specific Disease	Common Test	Evaluation Decision	INITIALS REQUIRED
Hepatitis B	Blood (HBsAg)	<input type="radio"/> agree to evaluation <input type="radio"/> refuse evaluation	
Hepatitis C	Blood (HCsAb)	<input type="radio"/> agree to evaluation <input type="radio"/> refuse evaluation	
Gonorrhea/Chlamydia	Cervical "Culture"	<input type="radio"/> agree to evaluation <input type="radio"/> refuse evaluation	
Syphilis	Blood (RPR)	<input type="radio"/> agree to evaluation <input type="radio"/> refuse evaluation	
HIV	Blood (HTLV III)	<input type="radio"/> agree to evaluation <input type="radio"/> refuse evaluation	

The statement below is required by Florida Statute:

I hereby give my consent to the administration of a blood test to detect the presence of the antibodies to the human immunodeficiency (HIV) virus. This virus causes the Acquired Immune Deficiency Syndrome (AIDS) and is considered important by my physician for my care and for the health of others. I have been provided with information regarding the methods of transmission of the HIV virus, about the test for antibodies to the HIV virus and the potential uses of these results. I understand about both the meaning and the limitations of the test results and know that no positive test result will be reported to me until a second confirming test has been performed. I have been given the opportunity to ask questions and understand that if my test results are positive, it may be necessary to see an Infectious Disease Specialist and take infectious disease precautions. Under these circumstances I understand that I will be provided with further counseling and information pertaining to my health and to the health of others. I understand that the performance of and results of the HIV test are confidential and that although the results will be placed in my records, under no circumstances will they be released without my permission, except to individuals and organizations that have been given access to them by law. By law, all positive HIV results must be reported to the County Health Department.

Patient's Signature:

Patient's Name (Please Print):

____/____/____
Date

Witness' Signature:

Witness' Name (Please Print):

____/____/____
Date