



Dedicated to Women  
OB-GYN

200 Banning Street, Suite 320  
Dover, DE 19904  
Phone: (302) 674-0223  
Fax: (302) 674-0109

209 E. Main St.  
Middletown, DE 19709  
Phone: (302) 389-4009  
Fax: (302) 376-5205

Robert H. Radnich, MD, FACOG  
Peter J. Wong, MD, FACOG  
Robert Q. Scacheri, MD, FACOG  
Robert B. Hartmann, Jr., MD, FACOG  
Laura B. Moylan, MD, FACOG  
Margaret R. Chou, MD, FACOG  
Michelle H. Cooper, MD, FACOG  
M. Scott Bovelsky, MD, FACOG  
Jemine L. Wayman, CNM  
Teresa A Harris, RN, WHNP  
Gayle A. Fosterling-Pearson, RN, WHNP

**CONSENT FORM  
FOR SPECIMEN COLLECTIONS  
FOR THE PURPOSE OF HIV ANTIBODY TESTING**

I have read and understand the HIV Antibody Test Information Sheet (initial here) \_\_\_\_\_.

Regarding the HIV Antibody Test, I understand:

- The meaning and limitation of the test.
- The Department of Health recommendations to reduce the risk of contracting or transmitting HIV.
- That the test is not a diagnostic test for AIDS.
- That my test results might cause me to experience psychological distress.
- That there are medicines available that can help prevent passing HIV to my baby should I have HIV.
- That the test results will appear on my chart.

All questions I have regarding the HIV Antibody Test, and my receiving of the test, have been answered to my satisfaction.

\_\_\_\_\_ I decline to have a blood sample taken for the purpose of HIV Antibody Testing.

\_\_\_\_\_ I consent to HIV Antibody Testing acknowledging that the test is voluntary and that my consent may be withdrawn prior to the taking of the blood specimen.

I sign this consent form unaltered.

Patient (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Patient Acct. ID# \_\_\_\_\_

HIV Antibody Test ordered by and informed consent received by \_\_\_\_\_, MD.