Division of Immigration Health Services

Pre & Post HIV Test Counseling and Consent Form

The following topic(s) were discussed and explained to the detainee:

Pre-Test Counseling

_____1. Purpose of Test
_____2. Confidentiality
_____3. Assessment of risk
_____4. Meaning of results
_____5. Risk factors
_____6. Prevention Recommendations
_____7. Informed Consent
_____8. Questions/Educational Materials
_____9. Return for Results

_____**Accepts Testing**
_____**Rejects Testing**

Detainee's Signature Date

Counselor's Signature Date

Counselor's Name Date

Title

Post-Test Counseling

_____1. Confidentiality
_____2. Test Results
_____3. Meaning of Results
_____4. Risk Reduction
_____5. Protective Health Habits
_____6. Questions/Educational Materials
_____7. Psychological Referral/Support Services
_____8. Partner Notification
_____9. Follow Up

Detainee's Signature Date

Counselor's Signature Date

Counselor's Name Date

Title

CONSENT

I, the undersigned, acknowledge that I consent to voluntary HIV Testing. I understand that the results will become part of my health record which is privileged and confidential information. I further understand that no additional release will be made without my written authorization unless required by law.

Signature of Detainee Date

PARTNER NOTIFICATION

Since I tested positive for HIV, I authorize the confidential notification of my sexual and/or IV drug partners as feasible by the:

_____DIHS Health Care Program _____Local Department of Health and Rehab Services

Detainee Signature Counselor Signature/Stamp

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
1. Name: (Last) (First)	
2. DOB:	3. A #
4. Nationality:	5. Facility: