



## Pediatric HIV Testing and Counseling Checklist

This Checklist accompanies the **Consent for Human Immunodeficiency Virus Test**. The counselor(s) will **discuss and document** in the patient's medical record the information included on this checklist. Asterisked items are mandatory. This checklist will be kept in the front of the chart until the post test results have been discussed with the patient/family, then place with the consent.

Initials of Counselor

<u>Pretest</u>	<u>Post-Test</u>	Discuss & Document:
_____	_____	1. The meaning of a positive HIV antibody test result <ul style="list-style-type: none"> <li>• Positive antibody test indicates infection with HIV in adults and children &gt; 18 months</li> <li>• Positive antibody test in infants &lt; 18 months of age may reflect passive transfer of maternal antibody - therefore a positive antibody test needs to be confirmed with virus-specific test</li> <li>• Duration of infection probably life-long</li> <li>• At risk for developing AIDS or AIDS related condition</li> </ul>
_____	_____	2. The meaning of a negative HIV antibody test result <ul style="list-style-type: none"> <li>• Probably not HIV-infected if &gt; 18 months of age and healthy</li> <li>• May be too early for the development of antibodies if infected within past 6 months</li> </ul>
_____	_____	3. Reliability of test <ul style="list-style-type: none"> <li>• False positive. &lt; 1% if confirmed by Western blot</li> <li>• False negative possible if child is very ill</li> </ul>
_____	_____	4. Patient / Family informed of test results <ul style="list-style-type: none"> <li>• Review #1 or #2 as applicable</li> </ul>
_____	_____	5. Explanation of HIV infection <ul style="list-style-type: none"> <li>• Virus attacks T<sub>4</sub> cells (part of the immune system)</li> <li>• Carrier state (analogy to Hepatitis B)</li> <li>• Spectrum of HIV disease</li> <li>• Effective therapy is available</li> </ul>
_____	_____	6. Modes of HIV transmission <ul style="list-style-type: none"> <li>• Sexual contact</li> <li>• Direct blood injection</li> <li>• Perinatal transmission</li> <li>• Casual, household contact NOT a mode of transmission</li> </ul>
_____	_____	7. Issues if counseling pregnant woman. <ul style="list-style-type: none"> <li>• Transmission of infection &lt; 10% if mother is taking antiretroviral therapy (67% decrease in transmission with maternal / infant zidovudine therapy)</li> <li>• No breast feeding</li> <li>• Mom should be referred to Northwest Family Center (NWFC) for consultation with HIV Obstetric Specialist (206) 731-3066</li> <li>• Infant zidovudine after birth and referral to NWFC for early diagnosis</li> </ul>
_____	_____	8. Infant Care (if applicable) <ul style="list-style-type: none"> <li>• Careful hand washing (before and after diaper change; gloves if blood, serum or diarrhea)</li> </ul>
_____	_____	9. Banked blood is tested for HIV and considered safe. Chances of receiving a contaminated unit are estimated at < 1 in 600,000 in Washington state.



Hospital & Regional Medical Center  
SEATTLE, WA 98105

**PEDIATRIC HIV TESTING AND COUNSELING  
CHECKLIST**

ADDRESSOGRAPH

CASE NO.

NAME

B-DATE

## Pediatric HIV Testing and Counseling Checklist (cont'd)

<u>Pretest</u>	<u>Post-Test</u>	
_____	_____	10. Provision of personalized risk reduction education <ul style="list-style-type: none"> <li>• Sexual abstinence</li> <li>• Mutually monogamous relationship between uninfected people</li> <li>• Do not share IV drugs and injection equipment</li> <li>• Safer sex guideline                             <ul style="list-style-type: none"> <li>◦ Use of condoms and spermicide (do not provide absolute protection)</li> <li>◦ Worn start to finish of vaginal, anal and oral intercourse</li> <li>◦ Latex dental dams for oral intercourse</li> <li>◦ Other STD's may increase risk of HIV transmission</li> </ul> </li> </ul>
_____	_____	11. Assess risk of acquiring and transmitting HIV <ul style="list-style-type: none"> <li>• H/o IVDU after 1977</li> <li>• Men engaging in unprotected sex with other men after 1977</li> <li>• H/o sex for money or drugs any time since 1977</li> <li>• Needle sharing or sexual contact with anyone with above behaviors</li> <li>• H/o multiple sexual partners</li> <li>• H/o exposure to or diagnosis with an STD</li> <li>• H/o blood transfusion prior to 1983</li> </ul>
_____	_____	12. Availability of anonymous testing <ul style="list-style-type: none"> <li>• Name or identity not linked to the result</li> <li>• Available through local health department</li> <li>• Not recommended if reason for HIV testing is for help with diagnosis and treatment of a medical condition</li> </ul>
_____	_____	13. Confidential testing <ul style="list-style-type: none"> <li>• Test results will be placed in the medical chart</li> <li>• Information not released without permission</li> <li>• Washington State law requires reporting of persons with positive HIV test results</li> </ul>
_____	_____	14. Need for and consequences of sharing HIV results with others <ul style="list-style-type: none"> <li>a. Sexual partners</li> <li>b. Relatives</li> <li>c. Friends</li> <li>d. School</li> <li>e. Housing</li> <li>f. Insurance</li> <li>g. Health care providers for yourself and child</li> <li>h. IV drug use partners</li> </ul>
_____	_____	15. Patient / Family support systems <ul style="list-style-type: none"> <li>• Identify support person(s) within social network</li> <li>• Provide referral for medical evaluation, and assistance with partner notification</li> </ul>
_____	_____	16. HIV literature / referrals for support and counseling given to patient/family (Contact HIV Social Worker through hospital paging operator)
_____	_____	17. Document in the medical chart <ul style="list-style-type: none"> <li>• Other patient questions / concerns that were discussed</li> <li>• Comments about patient / parent's coping ability</li> </ul>

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Patient/Legally Authorized Representative Name

\_\_\_\_\_  
Patient/Legally Authorized Representative Name



## CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS BLOOD TEST

I give permission for \_\_\_\_\_ (patient name) to be tested for the presence of the human immunodeficiency virus (HIV), the virus that causes the Acquired Immune Deficiency Syndrome (AIDS). I understand that these tests are performed by withdrawing blood and using substances to test the blood.

I understand that these tests will, in some cases, fail to reveal the presence of infection with this virus even though the virus is present. Thus, a negative test does not guarantee that the patient has not been infected with the virus (false negative). Also, in a small number of cases, the test results may indicate that the person has antibodies to the virus when the person does not (false positive).

I have been provided with information regarding the nature of this testing, its limitations, its expected benefits, its risks and alternative tests.

I understand that my physician will notify me of the results of the blood tests and that the results will be explained to me and that counseling will be available.

I understand that the results of these tests will be treated with confidentiality and will not be released without my consent except as authorized by law. I do recognize that persons within the hospital including physicians, nursing staff and other health care practitioners may require access to this information in the course of their duties, and accordingly, I consent to all such persons having access to the results of these tests.

I have been told about the blood tests to detect the human immunodeficiency virus and have had my questions answered. I agree to the tests being done.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE

NOTE: Patient 14 years of age and older must sign for self.

**Children's**  
Hospital & Regional Medical Center  
SEATTLE, WA 98105  
**CONSENT FOR HUMAN IMMUNODEFICIENCY  
VIRUS BLOOD TEST**

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