SOURCE TESTING/DECLINATION FORM

Date: _____

I, _____, have been informed that an exposure incident involving an employee of _____, occurred while performing a procedure involving my blood or other potentially infectious body fluid. The accident occurred on _____ (date).

As required by law, I have been requested to consent to a blood test for possible infection with hepatitis B, hepatitis C and HIV. I have been informed that the testing is to alleviate the employee's concerns and anxiety and to provide the health care professional treating the employee for this injury with the appropriate information to provide medical evaluation and treatment. I have been informed that, as required by law, the results of these tests will remain confidential between the exposed employee, physician treating the employee and me. I also understand that I will receive the results of my testing and that ALL expenses associated with this testing will be incurred by facility where the injury occurred.

I understand that I have NOT been exposed to any body fluid or disease, only the employee has been exposed to my blood or body fluid. I understand that I am at no risk of contracting a disease.

If I have further questions about this consent, I will discuss them with the office manager or physician.

PLEASE SIGN ONE CHOICE BELOW

I **consent** to having my blood tested for hepatitis B, C and HIV.

_____ _____

Signature of consenting source individual Date

I **refuse to consent** to having my blood tested for hepatitis B, C and HIV.

_____ _____

Signature of consenting source individual Date