



INFECTIOUS DISEASE SCREENING WAIVER

(Print Patient's full name)

My physician has advised me that I should get this testing done. In spite of my doctor recommending the tests, by initialing below I choose not to get this test done. I wish to proceed with infertility treatment.

<u>Initial</u>		<u>Initial</u>	
_____	CBC	_____	HIV
_____	SED RATE	_____	RPR
_____	HEPATITIS CORE AB	_____	HEPATITIS C
_____	HEPATITIS B SURFACE AG		

_____ I agree to the above tests and the options I have indicated.

_____ I decline the above tests and the options I have indicated.

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Witness Signature _____ Date _____