ORLANDO ARTHRITIS & RHEUMATOLOGY CLINIC

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Patient Name:_____ DOB:_____

Phone Number:_____

At Orlando Arthritis and Rheumatology Clinic, we are dedicated to providing holistic care that addresses all aspects of our patients' health. Recognizing the importance of comprehensive wellness, we now offer **HIV testing** as part of our commitment to your overall well-being.

Our team understands that managing rheumatic conditions requires a thorough approach, and we believe that regular HIV testing is a crucial component of maintaining optimal health. By integrating HIV testing into our services, we aim to ensure early detection and provide timely support and treatment options.

We have partnered with Central Florida Health Care Services (CFHCS), a Florida non-profit organization, to provide access to HIV screening to all patients at no cost. If you are interested in these services, please answer the questions below. Your answers to these questions are confidential. If you answer "Yes" to any of the following questions, CFHCS will contact you and provide resources for testing, counseling and prevention services, including no cost HIV testing through Quest Laboratories.

The Centers for Disease Control and Prevention (CDC) recommends that everyone aged 13 to 64 get tested for HIV at least once as part of routine health care.

Option: ❑ Decline to answer all

1. Have you ever been tested for HIV? ❑ Yes ❑ No ❑ I don't know ❑ Decline to answer
2. Are you at risk of contracting HIV or Hepatitis through blood exposures or sexual activities? ❑ Yes ❑ No ❑ Decline to answer
3. Would you like to be provided free testing for HIV? ❑ Yes ❑ No ❑ Decline to answer
4. Would you like to be provided no cost counseling, education and/or preventative services for HIV? ❑ Yes ❑ No ❑ Decline to answer

If you'd like to know more about CFHCS's program, please inform a staff member to receive additional information. Your well-being is our priority, and we are dedicated to offering the best possible care in a safe and supportive environment.

Your signature below indicates that you have read this document and completed the screening questions.

Patient Signature:_____ Date:_____

<u>For Clinic Use:</u>

Clinic Respresentative Signature:_____