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**Canadian Immigration Medical**

**H.I.V. TESTING (AIDS TEST)**

**Date:**

The Acquired Immunodeficiency Syndrome (AIDS) is caused by infection with a micro-organism known as the human immunodeficiency virus (HIV). Although this virus is relatively new, its incidence has increased rapidly and, at the present time, many of those infected will go on to develop full blown AIDS, which is a lethal disease that affects millions world-wide.

The doctor to whom you have been referred will take a small sample of blood which will then be sent to a central laboratory for testing. Your test and result will be protected by a strict code of confidentiality. In the unlikely event that your test proves positive, you will, no doubt, wish to receive professional counselling and it will therefore be necessary for you to name a doctor or clinic to whom we may refer the result. If the test proves negative, you may, on written request, have the result forwarded to your General Practitioner.

A positive test means that you have been exposed to the AIDS virus and have developed antibodies. It may mean that you are infectious and could infect others (e.g. by sexual intercourse or by donating blood). It does not, however, necessarily mean that you will develop full blown AIDS. A negative test reflects only the antibody status of an individual at the time of testing.

**When you have decided to take your physical examination, please bring this form to the above Doctor's practice office. The doctor will then ask you to sign**

**the declaration to show that you consent to the test and will witness it in your presence.**

State the name and address of a doctor or clinic to whom we may advise the above result if the test proves to be positive.

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***I declare that I am willing to undergo testing for HIV antibodies (AIDS Test) and consent to the taking of a sample of blood for this purpose. In the event of the test proving positive, I authorise Dr. Crowley's practice to inform the doctor/clinic nominated above.***

**Signature:** -----

**Witnessed by: Dr.** ----- **Date** -----