

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from [DOCTOR OR CLINIC]. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help benefits from programs receiving Federal funds, such as F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a [OPERATION]. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on

MONTH DAY YEAR

hereby consent of [DOCTOR] of my own free will to be sterilized by [DOCTOR]

a method called [METHOD]. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department only for determining if Federal laws were observed.

I have received a copy of this form.

Date [MONTH] [DAY] [YEAR] SIGNATURE

You are requested to supply the following information but it is not required:

- Sex and ethnicity designation (please check) American Indian or Alaska Native Asian or Pacific Islander Black (not Hispanic origin) Hispanic White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice by the person obtaining consent. I have also read him/her the consent form in [LANGUAGE] language and explained its contents to him/her. To the best of my knowledge and belief he/she understands this explanation.

SIGNATURE DATE

STATEMENT OF PERSON OBTAINING CONSENT

Before [NAME OF RECIPIENT] signed the

consent form, I explained to him/her the nature of the sterilization operation. The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SIGNATURE OF PERSON OBTAINING CONSENT DATE

FACILITY

ADDRESS

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon [NAME OF INDIVIDUAL TO BE STERILIZED] on

[DATE OF STERILIZATION OPERATION] I explained to him/her the nature of the sterilization operation

SPECIFY TYPE OF OPERATION

The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent forms. In these cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- (1) At least thirty days have passed between the date of individual's signature on this consent form and the date sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
Premature delivery
Individual's expected date of delivery:
Emergency abdominal surgery:
(Describe circumstances):

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from [redacted] (DOCTOR OR CLINIC). When I first asked for the operation, I was told that the decision to be sterilized is permanent. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to have a child in the future. I have rejected these methods and chosen to be sterilized.

I understand that I will be sterilized by an operation known as [redacted]. The discomforts, risks and consequences associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on [redacted] [redacted] MONTH DAY YEAR, hereby consent of my own free will to be sterilized by [redacted] (DOCTOR)

using a method called [redacted]. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to representatives of the Department of Health and Human Resources for Employees of programs or projects that I am participating in but only for determining if Federal funds were used.

I have received a copy of this form. Date [redacted] MONTH DAY YEAR

SIGNATURE [redacted] You are required to supply the following information but [redacted] is not required:

- Sex and ethnicity (please check)
 American Indian or Alaska Native
 Black (not Hispanic origin)
 Hispanic
 Asian or Pacific
 White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter was provided to assist the individual to be sterilized: I have read the information and advice by the person obtaining consent to him/her. To the best of my knowledge and belief he/she understands this explanation.

SIGNATURE [redacted] DATE [redacted]

STATEMENT OF PERSON OBTAINING CONSENT

I, [redacted] before [redacted] signed the consent form, I explained to him/her the nature of the sterilization operation [redacted]. The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is [redacted] 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SIGNATURE OF PERSON OBTAINING CONSENT [redacted] DATE [redacted]

FACILITY [redacted]

ADDRESS [redacted]

PHYSICIAN'S STATEMENT

I, [redacted] before I performed a sterilization operation on [redacted] individual to be sterilized.

I explained to him/her the nature of the sterilization operation [redacted].

The fact that [redacted] intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent forms. In these cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(3) At least thirty days have passed between the date of individual's signature on this consent form and the date sterilization was performed.

(4) The sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form. [redacted] of the following conditions apply: [redacted] fill in information requested.

- Premature delivery
 Individual's expected date of delivery: [redacted]
 Emergency abdominal surgery: [redacted]
Describe circumstances): [redacted]

23

Use the following instructions to complete the Sterilization Consent Form.

PART 1 CONSENT TO STERILIZATION

1	Enter the name of the physician or the name of the clinic from which the recipient received sterilization information.
2	Enter the type of operation (no abbreviations).
	Enter the recipient's date of birth (MM/DD/YYYY). 3
4	Enter the recipient's name.
5	Enter the name of the physician performing the surgery.
6	Enter the name of the type of operation (no abbreviations).
7	The recipient to be sterilized signs here.
8	The same recipient in #7 dates signature here.
9	Check one box appropriate for recipient. This item is requested but NOT required.

PART 2 INTERPRETER'S STATEMENT

10	Enter the name of the language the information was translated to.
11	Interpreter signs his/her name.
12	Interpreter dates his/her signature.

PART 3 STATEMENT OF PERSON OBTAINING CONSENT

13	Enter recipient's name.
14	Enter the name of the operation.
15	The person obtaining consent from the recipient signs here.
16	The person obtaining consent from the recipient dates their signature here.
17	The person obtaining consent from the recipient enters the name of the facility where surgery will be performed. The facility name has to be completely spelled out.
18	The person obtaining consent from the recipient enters the complete address of facility in #17 above. Address must be complete, including state and zip code.

PART 4 PHYSICIAN'S STATEMENT

19	Enter the recipient's name.
20	Enter the date of sterilization operation.
21	Enter the type of operation.

PART 4 PHYSICIAN'S STATEMENT (Continued)

- 22** Check applicable box:
- If premature delivery is checked, you must write in the expected date of delivery here.
 - If emergency abdominal surgery is checked, describe circumstances here.
-
- 23** Physician who performed sterilization signs here.
-
- 24** Physician enters the date of sterilization or a date after the sterilization procedure was performed.
-

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM

Federal regulations require that patients are informed before the operation that a hysterectomy will leave them sterile. This form must be completed before Medicaid can reimburse you for these procedures.

The Hysterectomy Acknowledgement Form is a multiple part carbon set document obtained from Consultec. This form is required to be attached to all Medicaid claims when the conditions listed in the Guidelines exist. (See Chapter 8, Medicaid Guidelines.)

GUIDELINES

The recipient is not sterile prior to the hysterectomy.

The recipient is not post-menopausal.

An emergency condition does not exist.

See section 11.9 in Chapter 11, Medicaid Handbook Guidelines, for hysterectomy procedures which require documentation.