

HYSTERECTOMY CONSENT FORM

Medicaid Recipient Name \_\_\_\_\_ Medicaid ID # \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date of Hysterectomy \_\_\_\_\_

**>>>>COMPLETE ONLY ONE OF THE REMAINING SECTIONS & COMPLETE ALL BLANKS IN SECTION<<<<**

**SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY**

**I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF REPRODUCING.**

\_\_\_\_\_  
PATIENT'S SIGNATURE DATE

\_\_\_\_\_  
WITNESS' SIGNATURE DATE

**SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE. CHECK ONLY ONE SELECTION.**

I certify that before I performed the hysterectomy procedure on the recipient listed below:

1 [ ] I informed her that this operation would make her permanently incapable of reproducing. **(This certification for retroactively eligible recipient only** – a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made.)

2 [ ] She was already sterile due to \_\_\_\_\_  
CAUSE OF STERILITY

3 [ ] She had a hysterectomy performed because of a life-threatening situation due to \_\_\_\_\_  
DESCRIBE EMERGENCY SITUATION

And the information concerning sterility could not be given prior to the hysterectomy. Life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE DATE

**SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT RECIPIENT ONLY**

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

\_\_\_\_\_  
WITNESS' SIGNATURE DATE PATIENT REPRESENTATIVE SIGNATURE DATE  
PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to \_\_\_\_\_

\_\_\_\_\_  
REASON FOR HYSTERECTOMY

And was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her I counseled her representative, orally and in writing that the hysterectomy would render that individual permanently incapable of reproducing; and the individual's representative has signed a written acknowledgement of receipt of the foregoing information.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE DATE