HYSTERECTOMY CONSENT AND PATIENT INFORMATION FORM

This hysterectomy would be performed even without the purpose of rendering

__________________________________________ permanently incapable of reproducing

Patient’s Name

because of medical reasons (purposes) unrelated to sterilization:

The reasons are:

__________________________________________

__________________________________________

Explain by:

I told __________________________________ and her representative ____________________________ (If one present)

both orally and in writing, that the medical procedure - hysterectomy - will render her permanently incapable of reproducing.

__________________________________________

Signature of Person Obtaining Surgical Consent

ACKNOWLEDGMENT:

I have received and understand both oral and written information explaining that a woman undergoing a hysterectomy will be permanently incapable of reproducing:

__________________________________________

Signature of Patient

Acknowledgment was not required because of one or more of the following circumstance(s) (Check applicable box):

☐ The individual was sterile at time of procedure due to ____________________________________________

☐ The individual required a hysterectomy on an emergency basis because of life threatening circumstances.

__________________________________________

Physician’s Signature

This form is to be completed for requests for hysterectomies. Attach one copy to Health Insurance Claim Form – Washington State (HCFA 1500) when requesting authorization for surgery from the department. A copy must go to the patient and one to her representative if present. The physician should also retain a copy.