



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:

Physician's Signature

Date

Explained 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

Date

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

Date

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

Date

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.

