DHS
Oregon Department
of Human Services

Client Name
Medicaid I.D. Number

Hysterectomy Consent

Complete **only one** of the sections below.

I. Cases where a woman is capable of bearing children

PHYSICIAN'S STATEMENT

This hysterectomy is not being performed for the sole purpose of rendering the above named patient permanently incapable of reproducing. The patient and her representative, if any, were informed both verbally and in writing that the surgical procedure, hysterectomy, would render her permanently incapable of bearing children. I am recommending a hysterectomy for this patient for the following medical reasons:

_____

_____

Physician's Signature	Date

PATIENT'S OR REPRESENTATIVE'S STATEMENT

Prior to the surgical procedure, I received and understood both oral and written information explaining that after undergoing a hysterectomy I will be permanently incapable of bearing children.

Patient's or Representative's Signature	Date

In this circumstance only, a copy of this form must be given to the patient and one copy must be given to her representative if the patient is represented by another person.

II. Cases of previous sterility or life-threatening emergency

The patient's acknowledgment was not required because of the following circumstance (check applicable box):

❒ The individual was sterile at the time of the hysterectomy. State the cause of the sterility:

_____

❒ The hysterectomy was performed under a life-threatening emergency situation in which I determined prior acknowledgment was not possible. Describe the nature of the emergency:

_____

_____

Physician's Signature	Date

III. Cases of retroactive Medicaid eligibility

(Complete section II for cases where the patient was previously sterile or the hysterectomy was performed under a life-threatening emergency.)

❒ Before I performed the hysterectomy, I informed the above-named patient the hysterectomy would make her permanently incapable of bearing children.

Physician's Signature	Date