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

Acknowledgement:

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. An additional sterilization consent form is not required. 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.

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