State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Health Care Administration Division

(Embossed I.D. Card Information)

HYSTERECTOMY ACKNOWLEDGEMENT

Identification Number	Category Code	Sec.	FM Code	Patient's Full Name	Sex M ( ) F (X)	Birthdate / /

I have informed _____
Name of Person to Have Hysterectomy

or _____ orally and by this statement that
Name of Her Representative, If Applicable

the hysterectomy she is to have will render her permanently incapable of reproducing.

_____ _____
Signature of Person Obtaining Authorization To Perform the Hysterectomy — Date

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TO BE COMPLETED BY PATIENT OR HER REPRESENTATIVE

I acknowledge that I received the above information.

_____ _____
Signature of Person to Have the Hysterectomy — Date

Or, if applicable:

_____ _____
Signature of Her Representative — Date

DHS 1145 (6/89)

ATTACH TO CLAIM