DEPARTMENT OF HUMAN SERVICES

DHS/Med-QUEST Division
Medical Standards Branch

STERILIZATION REQUIRED CONSENT FORM

Identification Number	Name of Health Plan	Patient's Full Name	Sex	Date of Birth
			M( ) F( )	/ /

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
Doctor or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am currently receiving or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me that will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____, The discomforts, risks
Name of Procedure

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____/_____/_____ . I, _____, hereby consent
Date of Birth Name of Patient

of my own free will to be sterilized by _____ by a method called _____.
Name of Licensed Physician Sterilization Procedure

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services, or employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Printed Name of Patient	Signature of Patient	Date

You are requested to supply the following information but it is not required: (check race and ethnicity designation)

( ) Black (not of Hispanic origin) ( ) Asian or Pacific Islander ( ) White (not of Hispanic origin)
( ) Hispanic ( ) American Indian or Alaskan native

STATEMENT OF INTERPRETER

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understands this explanation.

Printed Name of Interpreter	Signature of Interpreter	Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the consent form, I explained to him/her the nature of the _____,
Name of Patient Sterilization Procedure

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the patient that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the patient that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the patient is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Printed Name of Individual Obtaining Consent	Signature	Date

Name of Facility	Address	Phone Number

STATEMENT OF PHYSICIAN

Shortly before I performed a sterilization operation upon _____ on _____
Name of Patient Date of Sterilization

I explained to him/her the nature of the _____, the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure

the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the patient that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the patient is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

SELECT ONLY ONE OPTION:

☐ A. At least 30 days have passed between date the patient signed this consent form and date the sterilization was performed.

☐ B. This sterilization was performed less than 30 days but more than 72 hours after date of the patient's signature on this consent form because of the following circumstances (check applicable box and complete requested information).

( ) Premature delivery. Patient's expected date of delivery is: _____

( ) Emergency abdominal surgery. (describe circumstances): _____

_____

Signature of Physician	Date

DHS 1146 (Rev. 04/99) Original Copy - Physician Second Copy - Patient Third Copy - Hospital/Clinic