# STERILIZATION CONSENT FORM

**INSTRUCTIONS: COMPLETE AND DISTRIBUTE COPIES TO:**
ORIGINAL - PHYSICIAN; COPY - HOSPITAL; COPY - PATIENT;
COPY - DHS, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

| 1. Patient Name |
|---|
| 2. Beneficiary Number |

**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 3._____ *(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 Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting 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 which 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 4._____ (*specify type of operation*). The discomforts, risks 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 5._____*(date; mm/dd/yyyy)*.

I, 6._____ (*name of individual to be sterilized*), hereby consent of my own free will to be sterilized by 7._____ *(doctor)* by a method called 8._____ *(specify type of operation)*.

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.

9._____*(signature)*

10._____*(date; mm/dd/yyyy)*

You are requested to supply the following information, but it is not required.

11. Race and ethnicity designation (*please check*)

Ethnicity:
☐ Hispanic
☐ Not Hispanic or Latino

Race (*mark one or more*):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

## ■ INTERPRETER'S STATEMENT ■

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 12._____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

13._____(*Interpreter*)

14._____(*date; mm/dd/yyyy*)

## ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 15._____ *(name of individual)* signed the consent form, I explained orally to him/her the nature of the sterilization operation 16._____ *(specify type of operation),* 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 individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized 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 individual to be sterilized 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.

17._____*(Signature of person obtaining consent)* 18._____*(date)*

19._____*(facility)*

20._____*(address)*

## ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 21._____ *(name of individual to be sterilized)* on 22._____ *(date of sterilization operation),* I explained orally to him/her the nature of the sterilization operation 23._____*(specify type of operation)*, 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 individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

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

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

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days but not more than 180 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individuals signature on this consent form because of the following circumstances (*check applicable box and fill in information requested*):

24. ☐ Premature delivery. Expected date of delivery:_____
☐ Emergency abdominal surgery. Describe circumstances:

_____

_____

25._____(*Physician*)

26._____(*date; mm/dd/yyyy*)

## FEDERAL PAPERWORK REDUCTION ACT STATEMENT
## (OMB No. 0937-0166)

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

## Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations Part 50, Subpart B (relating to Sterilization of Persons in Federally Assisted Family Planning Projects), all sterilization procedures performed primarily for the purpose of sterilization require a valid consent form. Providers must complete all sections of the Sterilization Consent Form as applicable. All of the fields must be completed legibly in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form.

| | |
|---|---|
| **1. Patient Name:** | Enter the first and last name of the beneficiary. |
| **2. Beneficiary Number:** | Enter the 10 digit beneficiary identification number. |
| **3. Doctor or Clinic:** | Enter the name of the physician or clinic providing the information to the beneficiary. |
| **4. Specify Type of Operation:** | Specify the name of the sterilization operation. The name in this field should match all other instances where the name is required on the form. |
| **5. Date:** | Enter the beneficiary's date of birth in numerical format month/day/year. The beneficiary must be at least 21 years of age to give consent. |
| **6. Name of Individual to be Sterilized:** | Enter the first and last name of the beneficiary. |
| **7. Doctor:** | Enter the name of physician that will perform the procedure. |
| **8. Specify Type of Operation:** | Specify the name of the sterilization operation. The name in this field should match all other instances where the name is required on the form. |
| **9. Beneficiary's Signature:** | The beneficiary must sign the form (first and last names are required). |
| **10. Date:** | Enter the date the beneficiary signs the form. The beneficiary must date the form in numerical format month/day/year. The beneficiary must be at least 21 years old on this date. |
| **11. Race and Ethnicity Designation:** | This information is optional. Race and ethnicity designations are requested but not required. |

**Interpreter's Statement:**

An interpreter must be provided to assist the beneficiary if the beneficiary does not understand the language used on the consent form or the language used by the person obtaining the consent. If an interpreter is provided, this section must be completed in full. If an interpreter is not provided, this section should be left blank. The consent will be denied for incomplete information if this section is partially completed.

| | |
|---|---|
| **12. Language:** | Enter the name of the language used by the interpreter to communicate the information to the beneficiary. |
| **13. Interpreter's Signature:** | If an interpreter is used, the interpreter must provide a signature. If an off-site interpreter provides assistance (via telephone or video technology) in the completion of this form, the off-site interpreter is required to sign the form. |
| **14. Date:** | The interpreter must date the form in numerical format month/day/year. |
| **15. Name of Individual:** | Enter the first and last name of the beneficiary. |
| **16. Specify Type of Operation:** | Enter the name of the sterilization operation. The name in this field should match all other instances where the name is required on the form. |
| **17. Signature of Person Obtaining Consent:** | A signature is required from the person providing sterilization counseling. |
| **18. Date:** | The person obtaining consent must date the form in numerical format month/day/year. |
| **19. Facility:** | Enter the name of the facility where the beneficiary received the sterilization information. |
| **20. Address:** | Enter the address of the facility where the beneficiary received the sterilization information. |
| **21. Name of Individual to be Sterilized:** | Enter the first and last name of the beneficiary. |
| **22. Date of Sterilization Operation:** | Enter the date of the sterilization operation in numerical format month/day/year. |
| **23. Specify Type of Operation:** | Enter the name of the sterilization operation. The name in this field should match all other instances where the name is required on the form. |

**Instructions for use of alternative final paragraphs:**

The physician must attest to one of the following:

- Choose option (1) in all cases *except* in the case of premature delivery or emergency abdominal surgery.
- Choose option (2) in the case of premature delivery or emergency abdominal surgery.

**24. (Check applicable box if option (2) is selected)**

**Premature delivery:** ** In the case of premature delivery, the physician must state the expected date of delivery in numerical format month/day/year.

**Emergency Abdominal Surgery:** ** In the case of emergency abdominal surgery, the physician must describe the emergency.

**25. Physician's Signature:** The physician performing the sterilization procedure must certify and sign the Physician's Statement section of the Consent Form after the procedure has been performed.

**26. Date:** The date of the physician's signature must be in numerical format month/day/year.