Reset form Print form

Patient's name	Medicaid ID

HEALTH SYSTEMS DIVISION
Medicaid Programs

Oregon Health Authority

Hysterectomy Consent

Complete only one of the sections below

I. Cases where a woman is capable of bearing children

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.

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 or patient representative's signature Date

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