Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

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 A.F.D.C. 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 _____. 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 ____ (month), ____(day), ____ (year). I, _____, hereby consent of my own free will to be sterilized by _____(doctor or clinic) by a method called _____.

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.

Client's Signature:	Date of Signature: / / (month/day/year)

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

Race and Ethnicity Designation

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

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

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

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

Interpreter Signature:	Date of Signature: / / (month/day/year)

Statement of Person Obtaining Consent

Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation known as a _____, 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.

Signature of person obtaining consent:	Date of Signature: / / (month/day/year)

Facility name:	Facility address:

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on_____/_____/_____ at (date of sterilization), I explained to him/her the nature of the sterilization operation _____(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 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 individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery - Individual's expected date of delivery:_____/_____ /_____ (month, day, year)

Emergency abdominal surgery (describe circumstances): _____

Physician's Signature:	Date of Signature: / / (month/day/year)

Paperwork Reduction Act Statement

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, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR 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.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX