Hysterectomy Statement

NPI

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If the patient signs the hysterectomy statement prior to surgery:

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

Patient information

Patient name (Please print) _____

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Signature

x _____

Witness information

Witness name (Please print) _____

Signature Date (mm/dd/yyyy)

x _____ _____

If the provider fails to obtain the patient's statement prior to surgery, however, has informed her that she would be incapable of bearing children (this is an exception, not a rule, and will be reviewed as such):

PRIOR TO MY SURGERY ON _____(Date of surgery (mm/dd/yyyy)), I WAS INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

Patient information

Patient name (Please print) _____

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Signature

x _____

Witness information

Witness name (Please print) _____

Signature Date (mm/dd/yyyy)

x _____ _____

If the patient is sterile due to age, a congenital disorder, a previous sterilization, or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances (life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement. Federal regulations do not recognize metastasis of any kind as life threatening or an emergency):

Patient information

Patient name (Please print) _____

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

The above named patient was sterile prior to the hysterectomy due to:

_____

_____

OR A hysterectomy was performed on the above named patient on an emergency basis, and the patient was unable to respond because of the following life-threatening circumstances:

_____

_____

Physician information

Physician name (Please print) _____

Signature		Date (mm/dd/yyyy)
x		