

### CONSENT FOR STERILIZATION

**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 \_\_\_\_\_ . When I first asked \_\_\_\_\_  
*Doctor or Clinic*

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 \_\_\_\_\_ . The discomforts, risks  
*Specify Type of Operation*

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: \_\_\_\_\_  
*Date*

I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_  
*Doctor or Clinic*

by a method called \_\_\_\_\_ . My  
*Specify Type of Operation*  
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 the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

\_\_\_\_\_  
*Signature* *Date*

You are requested to supply the following information, but it is not required: (*Ethnicity and Race Designation*) (please check)

- Ethnicity:*  
 Hispanic or Latino  American Indian or Alaska Native  
 Not Hispanic or Latino  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 \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_  
*Interpreter's Signature* *Date*

#### ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before \_\_\_\_\_ signed the  
*Name of Individual*  
consent form, I explained to him/her the nature of sterilization operation \_\_\_\_\_, the fact that it is  
*Specify Type of Operation*

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 consequences of the procedure.

\_\_\_\_\_  
*Signature of Person Obtaining Consent* *Date*

\_\_\_\_\_  
*Facility*

\_\_\_\_\_  
*Address*

#### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

\_\_\_\_\_ on \_\_\_\_\_  
*Name of Individual* *Date of Sterilization*

I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is  
*Specify Type of Operation*

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 paragraph:** 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: \_\_\_\_\_  
 Emergency abdominal surgery (*describe circumstances*): \_\_\_\_\_

\_\_\_\_\_  
*Physician's Signature* *Date*

### **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, 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]

## Division of Medicaid and Health Financing Attachment: Physician Manual Consent for Sterilization Form Instructions

Per Title 42 *Code of Federal Regulations* (CFR) 50, Subpart B, all sterilizations require a valid consent form. Ensure all required fields are completed for timely processing.

For prior authorization requests:

Submit the Request for Prior Authorization and the Sterilization Consent Form to:

Utah Medicaid Attn: Prior Authorization Unit  
P.O. Box 143111 Salt Lake City, Utah 84114-3111

Fax: (801) 536-0162

For claims processing:

Submit the [Utah Medicaid Documentation Submission Form](#) and the completed Sterilization Consent Form to:

Fax: (801) 237-0745

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the request will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

**30-day Rule:** There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

**Exceptions:**

1. Premature delivery - There must be at least 30 days between the date of consent and the client's expected date of delivery.
2. Emergency Abdominal Surgery – There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

**Use most current form:** This Sterilization Consent Form may be copied for provider use. Providers are encouraged to obtain current versions of the form from the Medicaid website listed above to ensure the appropriate form is submitted.

**Listed below are field descriptions for the Sterilization Consent Form. Completion of ALL sections is required to validate the consent form, with only two exceptions:**

**Exceptions:**

Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

**Required Fields:**

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

**Consent to Sterilization**

- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Date of Birth (month, day, year).
- Client's Name (first and last names are required).
- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Signature.

- Date of Client's Signature - *Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.*

#### **Interpreter's Statement (If applicable)**

- Name of Language Used by Interpreter.
- Interpreter's Signature.
- Date of Interpreter's Signature (month, day, year).

#### **Statement of Person Obtaining Consent**

- Client's Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent -The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an *original signature*, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the client's signature date.
- Facility Name - Clinic/office where the client received the sterilization information.
- Facility Address - Clinic/office where the client received the sterilization information.

#### **Physician's Statement**

- Client's Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician's Signature - Stamped or computer-generated signatures are not acceptable.
- Date of Physician's Signature (month, day, year) - This date must be *on or after* the date of surgery.

#### **Note for Hysterectomy Procedures:**

The Sterilization Consent Form is not the appropriate form for hysterectomy procedures. The Hysterectomy Acknowledgment Form is required for ALL hysterectomy procedures and can be found at:

<http://health.utah.gov/medicaid/provhtml/forms.htm>

(select Hysterectomy Consent from drop-down list)