

**Department Of Vermont Health Access**

**Hysterectomy Consent Form**

A hysterectomy is surgery to remove your uterus (womb). You may also have your cervix, ovaries, and fallopian tubes removed. A hysterectomy cannot be reversed and it will permanently prevent you from becoming pregnant or having children.

I have been informed orally and in writing that I will be permanently incapable of becoming pregnant or having children after a hysterectomy. I understand that my hysterectomy, to be performed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date of surgery), will make me permanently incapable of becoming pregnant or having children.

Date: \_\_\_\_\_\_\_\_\_ (MM/DD/YR) DOB: \_\_\_\_\_\_\_\_ Medicaid UID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Representative: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Certification**

I, the undersigned physician, hereby certify that I have discussed the hysterectomy procedure with this patient, including the risks and benefits of the procedure, any adverse reactions that may possibly occur, and any alternative efficacious methods of treatment which may be medically viable. The hysterectomy I performed for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_ (date of surgery) was not performed solely or primarily in order to render her permanently incapable of reproducing.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YR) Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM or PM

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unusual Circumstances**

* Patient was already sterile when the hysterectomy was performed. Cause of sterility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Medical records are attached.
* Hysterectomy was performed under a life threatening situation. Medical records are attached.
* Hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.