**Ohio Department of Job & Family Services**
**CONSENT TO HYSTERECTOMY**

***Note:*** *Type of print clearly.*

**Section I: Identifying Information**

| Patient's Name | Physician's Name |
|---|---|
| Medicaid Number | Provider Number *(7-digit)* |
| Date of Surgery | Physician's Signature |

**Section II. Consent** *(If consent is not required, go on the Section III.)*

I understand that this hysterectomy, whether performed as a single procedure or together with other procedures, is medically necessary and is not to be performed solely for family planning purposes.

The fact that the surgery will make me permanently incapable of bearing children in the future has been explained to me orally and in writing.

☐ Consent **before** surgery - I understand the above statements.

☐ Consent **after** surgery - I understand the above statements. The were explained to me orally and in writing before surgery.

| Patient/Representative Signature | Date of Signature | Person Obtaining Consent *(if other than physician)* |
|---|---|---|
| | | |

**Sections III: Exceptions**

☐ 1. Prior Sterility, explain: ______________________________.

☐ 2. Post menopause age ______________.

☐ 3. Patient required a hysterectomy because of a life-threatening emergency in which prior consent was not possible. Explain emergency:

______________________________

______________________________

**Section IV: Retroactive Eligibility**

At time of the hysterectomy Medicaid eligibility was not established. For retroactive payment check boxes that apply and complete information requested.

☐ 1. Patient was informed of the consequences of the procedure and has signed the consent form in Section II.

☐ 2. Patient was not informed of the consequences of the procedure but:

- ☐ Was sterile prior to surgery. Explain ______________________________.
- ☐ Was post menopause age ______________.
- ☐ Required a hysterectomy because of a life-threatening emergency in which prior consent was impossible. Explain Emergency ______________________________

**Distribution:** One copy to patient; one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist. FOR REIMBURSEMENT EACH PROVIDER MUST SEND A COPY OF THIS FORM TO OHIO DEPARTMENT OF JOB & FAMILY SERVICES.