



**CONSENT FORM**

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.

**PART I CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from \_\_\_\_\_ . When I first asked for the \_\_\_\_\_ (Doctor or clinic)

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) 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.  
Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Month Day Year

**MEDICAID ID NUMBER**

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

- American Indian or Alaska Native
- Black (not of Hispanic origin)
- Hispanic
- Asian or Pacific Islander
- White (not of Hispanic origin)

**PART II 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 \_\_\_\_\_ Date \_\_\_\_\_

**PART III STATEMENT OF PERSON OBTAINING CONSENT**

Before \_\_\_\_\_ signed the \_\_\_\_\_ (Name of individual)

Consent form, I explained to him/her the nature of the sterilization 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 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 \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_

**PART IV PHYSICIAN'S STATEMENT**

Shortly before I performed a sterilization operation upon \_\_\_\_\_ on \_\_\_\_\_ (Name: Individual to be sterilized) (Date sterilized)

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 discomfort, 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 circumstance (check applicable box and fill in information requested):

- Premature delivery  
Individual expected date of delivery: \_\_\_\_\_
- Emergency abdominal surgery (describe circumstance): \_\_\_\_\_

Physician \_\_\_\_\_ Date \_\_\_\_\_

License No: \_\_\_\_\_ Group No: \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM

All sections of the "Sterilization for Medicaid Recipients" consent form (SCDHHS form 1723, Jan. 1989 edition) must be completed. If the consent form is correctly completed and meets the Federal Regulations, the service may be rendered. Please see the Correctable/Non-Correctable Error Chart for a listing of errors that can and cannot be changed on a Consent form. Listed below are instructions on completing the form followed by the Error Chart.

### Part I

1. Name of physician or group scheduled to do sterilization procedure. If the physician or group is unknown, put the phrase "OB on call".
2. Name of the sterilization procedure (i.e., bilateral tubal ligation [BTL]).
3. Birth date of the member. The member must be 21 years old when he/she signs the consent form.
4. Member's name.
5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call".
6. Name of the sterilization procedure.
7. Member's signature and date. If the member signs with an "X", an explanation must accompany the consent form.
8. Member's Medicaid number.

### Part II

9. If the member had an interpreter translate the consent form information in a foreign language (i.e., Spanish, French, etc.), the interpreter must complete this section. **If an interpreter was not necessary, put N/A in these blanks.**

### Part III

10. Member's name.
11. Name of sterilization procedure.

12. Signature and date of the person who counseled the member on the sterilization procedure. This date should match the date of the member's signature date. Also complete the facility address. An address stamp is acceptable if legible.

**Part IV (This part is completed after the sterilization procedure is performed).**

13. Member's name.
14. Date of the sterilization procedure. (Be sure this date matches the date on the claim.)
15. Name of the sterilization procedure.
16. EDC date is required if sterilized within the 30 day waiting period and the member was pregnant.
17. An explanation must be attached if an emergency abdominal surgery was performed within the 30 day waiting period. At least 72 hours is required to pass before the sterilization and the sterilization procedure may not be the reason for the emergency surgery.

**Please note: If the member is pregnant, premature delivery is the only exception to the 30 day waiting period.**

18. Physician signature and date. A physician's stamp is acceptable. The rendering or attending physician must sign the consent form. The physician's date must be dated the same as the sterilization date or after.

Correctable/Non-Correctable Error Chart for Sterilization Consent Form	
A. Doctor or Group Name	Correctable Error
B. Name of Procedure	Correctable Error
C. Patient Date of Birth	Correctable Error. Date of Birth on the CMS 1500 form, and consent form should all match. Patient <b>MUST</b> be 21 years old to sign form.
D. Patient Name	Correctable Error. Name should match name on the CMS 1500 form.
E. Doctor or Group Name	Correctable Error
F. Name of Procedure	Correctable Error
G. Patient Signature	NOT A CORRECTABLE ERROR. The signature must be the patient's signature. If the patient is unable to sign or signs with an "X", an explanation must accompany the consent form.
G. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation.
H. Medicaid ID Number	Correctable Error
Part II – Interpreter's Statement	
A. Foreign Language Used	Correctable Error
A. Interpreter Signature	Correctable Error
A. Date	Correctable Error
Part III – Statement of Person Obtaining Consent	
A. Patient Name	Correctable Error
B. Procedure	Correctable Error. This procedure must match B and F.
C. Signature of Person Obtaining Consent	NOT A CORRECTABLE ERROR
C. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation. This date must match PART I-G. *
C. Facility Address	Correctable Error. An address stamp is acceptable if legible.
Part IV – Physician's Statement	
A. Patient's Name	Correctable Error
B. Date of Procedure	Correctable Error. This date must match the date of service on the claim form.
C. Procedure	Correctable Error. This procedure must match PART I B and F, and procedure code on claim.
D. Expected Date of Delivery	Correctable Error
D. Emergency Abdominal Surgery	Correctable Error. An explanation must be attached to the claim.
F. Physician Signature	Correctable Error. A physician's stamp is acceptable.
F. Date	NOT A CORRECTABLE ERROR if the date is prior to the sterilization without detailed medical records documentation. * CORRECTABLE ERROR if field is blank.
F. License Number (Medicaid Individual Provider Number)	Correctable Error. The provider number is the same as on the CMS claim form.
F. Group Number (Medicaid Group Provider Number)	Correctable Error. The group provider number is the same as on the CMS claim form.

\* Most commonly occurring errors.