Oregon Health Authority
Health Systems Division
Medicaid Programs

Patient's name	Medicaid ID

Consent to Sterilization (Ages 21 and older)

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.

Patient's statement

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked 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 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 of 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 the Department but only for determining if federal laws were observed.

I have received a copy of this form.

_____ _____
Signature Date (month/day/year)

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (mark one or more): ☐ American Indian or Alaska Native ☐ 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.

_____ _____
Signature Date (month/day/year)

Statement of person obtaining consent

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____ (name of 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 consequences of the procedure.

_____ _____

Signature of person obtaining consent | Date (month/day/year)

Facility: _____

Address: _____

Physician's statement

Shortly before I performed a sterilization operation upon _____ (name of individual) on _____ (date of sterilization operation), 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 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 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 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 _____ (month/day/year).
- ☐ Emergency abdominal surgery (describe circumstances): _____

_____ _____

Physician's signature | Date (month/day/year)

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