Sterilization Process

Health plans require us to monitor providers and track all sterilization candidates to ensure that they have received proper education prior to their procedure.

- Upon first visit, members must be offered the Educational Sterilization Booklet
  - Copy of this can be printed at http://www.dhcs.ca.gov
  - Enter "*Sterilization*" in the search field
  - Select Permanent Birth Control
  - Offered in English and Spanish

- Document that this was given to the patient in their chart

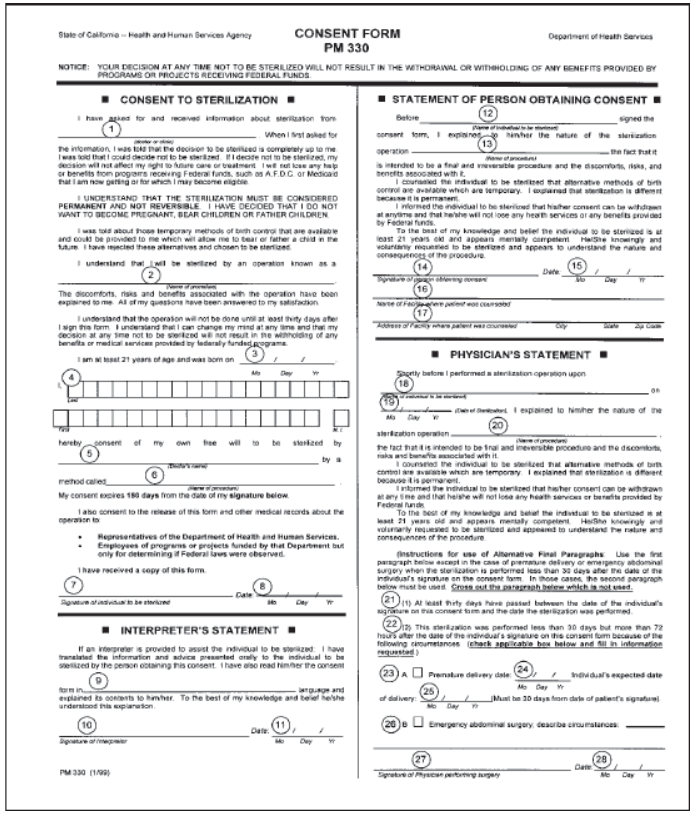
- Have member complete the required PM 330 for Medi-cal or 284 form for Commercial

- Complete Prospect Sterilization log

- Fax all listed back to us as one member package to (909) 931-5077

Sterilization Process

Sample Documents



State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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 (1) _____. When I first asked for (doctor or clinic)
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 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 (2) _____. (Name of procedure)
The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty 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 (3) ___/___/___ Mo Day Yr

(4) _____ Last

_____ First M.I.

hereby consent of my own free will to be sterilized by (5) _____ by a (Doctor's name)
method called (6) _____. (Name of procedure)

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.**
- **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.

(7) _____ Date (8) ___/___/___
Signature of individual to be sterilized Mo Day Yr

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 (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter Mo Day Yr

PM 330 (1/99)

STATEMENT OF PERSON OBTAINING CONSENT

Before (12) _____ signed the (Name of individual to be sterilized)
consent form, I explained to him/her the nature of the sterilization operation (13) _____ the fact that it (Name of procedure)
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 anytime 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.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent Mo Day Yr

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled City State Zip Code

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) _____ on
(Name of individual to be sterilized)

(19) ___/___/___ (Date of Sterilization). I explained to him/her the nature of the Mo Day Yr

sterilization operation (20) _____.
(Name of procedure)

the fact that it is intended to be 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 when 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 below which is not used.**

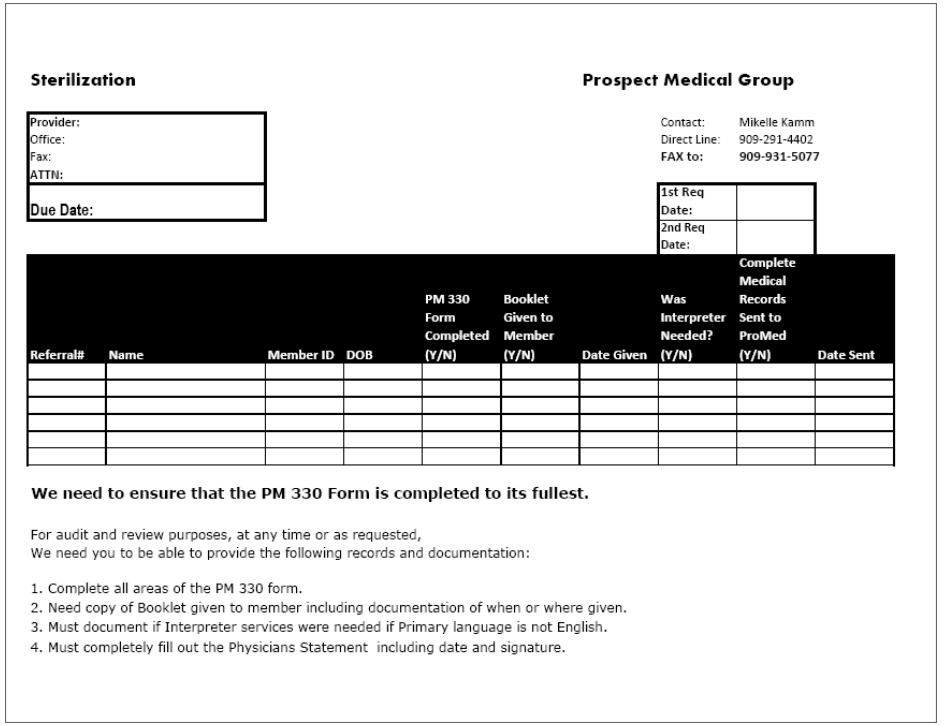
(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (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 below and fill in information requested.)**

(23) A ☐ Premature delivery date: (24) ___/___/___ Individual's expected date Mo Day Yr
of delivery: (25) ___/___/___ (Must be 30 days from date of patient's signature)
Mo Day Yr

(26) B ☐ Emergency abdominal surgery, describe circumstances: _____

(27) _____ Date: (28) ___/___/___
Signature of Physician performing surgery Mo Day Yr



Sterilization

Prospect Medical Group

Provider:	
Office:	
Fax:	
ATTN:	
Due Date:	

Contact:	Mikelle Kamm
Direct Line:	909-291-4402
FAX to:	909-931-5077

1st Req Date:	
2nd Req Date:	

Referral#	Name	Member ID	DOB	PM 330 Form Completed (Y/N)	Booklet Given to Member (Y/N)	Date Given	Was Interpreter Needed? (Y/N)	Complete Medical Records Sent to ProMed (Y/N)	Date Sent

We need to ensure that the PM 330 Form is completed to its fullest.

For audit and review purposes, at any time or as requested,
We need you to be able to provide the following records and documentation:

1. Complete all areas of the PM 330 form.
2. Need copy of Booklet given to member including documentation of when or where given.
3. Must document if Interpreter services were needed if Primary language is not English.
4. Must completely fill out the Physicians Statement including date and signature.

Sterilization Process

Sample Documents

State of California—Health and Human Services Agency — California Department of Public Health

STERILIZATION CONSENT FORM (NON-FEDERALLY FUNDED)

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

_____
(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 understand that I can change my mind at any time.

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 undergo 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 except in specific instances that have been fully explained to me.

I wish to waive the 30-day waiting period to _____ days (not less than 72 hours).

I am at least 18 years of age.
OR
I am under 18 **AND**
I have entered into a valid marriage, **OR**
I am on active duty with the U.S. armed services, **OR**
I have received a declaration or emancipation pursuant to Section 64 of the Civil Code, **OR**
I am over 15 years old, live apart from my parents or guardians, and manage my own financial affairs.

I was born on _____
(Month) (Day) (Year)

I, _____, hereby consent of my own free will to undergo an operation intended to sterilize me, to be performed by _____
(Doctor)

by a method called _____.

I am not in labor and it has been at least 24 hours since I gave birth or had an abortion. I am not seeking to obtain or obtaining an abortion at this time.

I am not under the influence of alcohol or other substances that affect my state of awareness.

I understand that I may have a witness of my choice present during the time my consent is obtained.

My consent expires 180 days from the date of my signature below.

I have received a copy of this form.

_____ _____
(Signature) (Date [Month/Day/Year])

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 [Month/Day/Year])

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 18 years old, or meets the necessary age requirements under applicable regulations, and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

I certify that I explained orally to the person to be sterilized the requirements for informed consent as set forth on this form and in applicable regulations.

_____ _____
(Signature of Person Obtaining Consent) (Date)

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____

_____ on _____,
(Name of individual to be sterilized) (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 18 years old, or meets the necessary age requirements under applicable regulations, 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, or patient waiver 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. I certify that 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):

a. Premature delivery:
Individual's expected date of delivery: _____
b. Emergency abdominal surgery (describe circumstances):
_____
Date individual intended to be sterilized: _____
c. Patient waived the 30-day waiting period to _____ days. (Not less than 72 hours.)

_____ _____
(Physician) (Date)

PM 284 (ENG/SP) (7/07) — Page 1 of 2

State of California—Health and Human Services Agency — California Department of Public Health

FORMULARIO DE PERMISO LA ESTERILIZACIÓN (CON FONDOS NO FEDERALES)

NOTA: SI EN CUALQUIER MOMENTO DECIDE NO HACERSE ESTERILIZAR ELLO NO RESULTARA EN QUE SE LE RETIREN O RETENGAN CUALQUIERA DE LOS BENEFICIOS PROPORCIONADOS POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS DEL GOBIERNO FEDERAL.

PERMISO PARA ESTERILIZACIÓN

He pedido y recibido información sobre la esterilización de

_____
(Doctor o Clínica)

Cuando me informé al respecto, se me dijo que la decisión de permitir que se me esterilice es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no permitir que se me esterilice. Si decido no permitir que se me esterilice, esta decisión no afectará mis derechos a cuidados o tratamientos futuros. Entiendo que puedo cambiar de opinión en cualquier momento.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA **PERMANENTE** E **IRREVOCABLE.** HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, TENER O PROCREAR HIJOS.

Se me ha informado acerca de los métodos anticonceptivos temporarles que están disponibles y que se me podrán proporcionar, los que si me permitirán procrear un hijo en el futuro. He rechazado estas alternativas y he elegido ser esterilizado(da).

Entiendo que se me hará una operación conocida bajo el nombre de

_____

Los malestares, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no será realizada por lo menos 30 días después de haber firmado este formulario, con excepción de situaciones especificas que me han sido minuciosamente explicadas.

Deseo renunciar el derecho de tener 30 días de espera. En cambio, estoy de acuerdo en esperar _____ días. (No menos de 72 horas.)

Tengo por lo menos 18 años de edad.
o
Soy menor de 18 años de edad, *y*
Estoy casado(da) legalmente, *o*
Estoy en servicio activo en las fuerzas armadas de los EEUU, *o*
He recibido una declaración de emancipación de acuerdo a la Sección 64 del Código Civil, *o*
Tengo más de 15 años de edad, vivo separado(da) de mis padres o guardianes, y manejo mis asuntos financieros.

Naci en _____
(Mes) (Día) (Año)

Yo, _____, por mi firma doy mi permiso a que se me haga una operación cuyo fin es el de estirilizarme, y que será hecha por _____
(Doctor)

por el método conocido como _____.

No estoy en trabajo de parto y han transcurrido por lo menos 24 horas desde que di a luz o tuve un aborto. Yo no estoy buscando u obteniendo un aborto en este momento.

No estoy bajo la influencia del alcohol u otras substancias que afecten mis facultades.

Entiendo que puedo tener un te´stigo de mi preferencia presente en el momento que dé el permiso para que se me esterilice.

Mi permiso se vence a los 180 días de la fecha de mi firma.

He recibido una copia de éste formulario.

_____ _____
(Firma) (Fecha [Mes/Día/Año])

DECLARACIÓN DEL INTÉRPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos oralmente por la persona que obtiene este permiso, a la persona a ser esterilizada. También le he leido el formulario de permiso en español y le he explicado su contenido. Según mi mejor entender el/ella ha comprendido esta explicación.

_____ _____
(Intérprete) (Fecha [Mes/Día/Año])

DECLARACIÓN DE LA PERSONA QUE OBTIENE ESTE PERMISO

Antes de que _____ firmara este
(Nombre de la Persona)

formulario de permiso, le expliqué la naturaleza de la operación para la esterilización llamada _____
el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los malestares, riesgos y beneficios que la acompañan.

Yo advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarles. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento a cualquier momento y que el/ella no perderá ninguno de los servicios de salud o cualquier otros beneficios proporcionados con fondos federales.

De acuerdo a mi mejor entender y creer la persona a ser esterilizada tiene por lo menos 18 años de edad, o reune los requisitos necesarios de edad bajo los reglamentos en vigor, y parece mentalmente competente. El/Ella sabiendo y voluntariamente ha solicitado ser esterilizado(da) y parece comprender la naturaleza y consecuencias del procedimiento.

Yo certifico que le he explicado a la persona a ser esterilizada los requisitos por el entendimiento de permiso. Según está suscrito en este formulario y en regulaciones pertinentes.

_____ _____
(Firma de la Persona que Obtiene el Permiso) (Fecha)

_____
(Establecimiento)

_____
(Dirección)

DECLARACIÓN DEL MÉDICO

Poco antes de efectuar la operación para la esterilización de _____

_____ el _____,
(Nombre de la Persona a ser Esterilizada) (Fecha de la Operación de Esterilización)

yo le expliqué la naturaleza de la operación llamada

_____
(Tipo de Operación)

el hecho de que es un procedimiento final e irrevocable, y los malestares, riesgos y beneficios derivados del mismo.

Yo advertí a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarles. Yo le expliqué que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su permiso puede ser retirado en cualquier momento y que por ello el/ella no perderá ninguno de los cuidados médicos o beneficios proporcionados con fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 18 años de edad, o reune los requisitos de edad necesarios bajo los reglamentos en vigor, y parece mentalmente competente. He pedido voluntariamente y con pleno conocimiento ser esterilizado(da) y parece comprender la naturaleza y consecuencias del procedimiento.

(Instrucciones para el uso de los párrafos finales alternos: Utilice el primer párrafo que sigue, excepto en casos de parto prematuro, cirugía abdominal de emergencia o renuncia del paciente pare que la esterilización se efectúe en menos de 30 días después de la fecha de la firma del formulario de permiso. En dichos casos, deberá usarse el segundo párrafo. Tache el párrafo que no utilice.)

1. Por lo menos 30 días han transcurrido entre la fecha en que la persona firmó el formulario de permiso y la fecha en que se efectuó la operación de esterilización.

2. Yo certifico que esta esterilización fue efectuada antes de los 30 días pero después de 72 horas de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y dé la información requerida):

a. Parto prematuro:
Fecha en que debería haber ocurrido el parto: _____
b. Cirugía abdominal de emergencia (describa las circunstancias):
_____
Fecha en que la persona intentó ser esterilizada: _____
c. El/La paciente renunció el derecho al periodo de espera de 30 días a cambio de un periodo de espera de _____ días. (No menos de 72 horas.)

_____ _____
(Médico) (Fecha)

PM 284 (ENG/SP) (7/07) — Page 2 of 2

ProMed Health Care Administrators

Office Manager Updates
Physician Memo

Sterilization

Just a friendly reminder when submitting referrals for Sterilization, we need the following information: (Please note: this information is also required for our Health Plan Audits.) Information is available on our website www.prospectmedical.com under the For Providers section and Training Modules link.

Information Required:

- Completed members PM 330 Sterilization Informed consent Form. (Physician section of form completed with signature and date). Consent form must be attached with all Medi-Cal Sterilization Claims. *Office Ally does not support attachments with claim submissions, so you may need to* ***mail in paper claims*** *to* **Prospect Medical, Attention Claims Department, P.O. Box 11466, Santa Ana, CA 9211-1466**

- If a laparoscopy with removal of the adnexal structures (CPT code 58661), salpingectomy (CPT code 58700) or a salpingo-oophorectomy (CPT code 58720) is performed, the claim must clearly indicate whether the procedure was:
  - A unilateral procedure that will not produce sterility
  - A bilateral procedure that will produce sterility

- Offer an Interpreter if there is evidence that the member did not understand the language and/or text of the consent process.

- Make sure member is 21 years of age at the time the consent was obtained, Not mentally incompetent, is able to understand the content and nature of the consent process

- Sterilization must be completed at least 30 days but not more than 180 days after the date upon which the consent form was dated. (Must document any emergency abdominal sx's or premature deliveries)

Sterilization

- Have complete medical records, Follow-up on any recommendations by the specialist, Follow-up on missed/broken appointment.

- Must have Copy of the DHCS member informational booklet provided to the member.

We need to ensure that the PM 330 Form is completed.

For audit and review purposes, at any time or as requested, we need you to be able to provide the following records and documentation:

- Completed PM 330 form
- Copy of Booklet given to member

Some examples of incomplete information in records received from past audits responses are:

- Member's primary language if not English, no Interpreter was provided.
- Physician did not complete Physicians Statement.
- No documentation of procedure date.
- No documentation if DHS booklet was given to member.
- Signature and date missing on form.

Please contact me at any time if you have any questions or issues regarding this request.

Thank you in advance for your assistance and cooperation.

Michelea Stanford, UM Compliance Manager- 909-758-4644
Dawn Tumser, Network Manager- 909-758-4673

Example of PM-330 Sterilization Consent Form

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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 (1) _____ (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 [illegible] A.F.D.C. or Medicaid that I am now g[illegible].

I UNDER[illegible] BE CONSIDERED **PERMANENT** [illegible]D THAT I DO NOT WANT TO BEC[illegible]THER 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 (2) _____ (Name of procedu[illegible]). The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I [illegible] not be done until at least thirty days after [illegible] change my mind at any time and that my [illegible] will not result in the withholding of any [illegible] federally funded programs.

I, [illegible] was born on (3) ___/___/___ Mo Day Yr.

(4) _____ Last First M. I.

hereby consent of my own free will to be sterilized by (5) _____ (Doctor's na[illegible]) by a method called (6) _____ (Name of procedure).

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.**
- **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.

(7) _____ *Signature of individual to be sterilized* Date: (8) ___/___/___ Mo Day Yr

■ 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 (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ *Signature of Interpreter* Date: (11) ___/___/___ Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERS[illegible]NSENT ■

Before (12) Penny L. Sillen, (Name of individual to be sterilized) signed the consent form, I explained to [illegible]ization operation (13) Bilateral Tubal Ligation (Name of procedure) 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 anytime 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.

(14) _____ *Signature of person obtaining consent* Date: (15) ___/___/___ Mo Day Yr

(16) _____ *Name of Facility where patient was counseled*

(17) _____ *Address of Facility where patient was counseled* City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly b[illegible] (18) Penny L. Sillen, (Name of individual to be sterilized) n operation upon _____ on (19) ___/___/___ Mo Day Yr (Date of Sterilization), I explained to him/her the nature of the sterilization operation (20) Bilateral Tubal Ligation (Name of procedure).

the fact that it is intended to be 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/sh[illegible]y Federal funds.

To the best of my [illegible]t least 21 years old and [illegible]d voluntarily requested to b[illegible]d consequences of the proc[illegible].

(**Instructions for use of Alternative Final Paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when 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 below which is not used.**

(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (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 below and fill in information requested.**)

[illegible] **individual's expected date** [illegible] of patient's signature).

[illegible] mstances: _____

(27) Marcus J. Welby M.D. *Signature of Physician performing surgery* Date: (28) ___/___/___ Mo Day Yr

Fields 2, 6, 13, & 20
Bilateral Tubal Ligation

Fields 4, 7, 12, & 18
Penny L. Sillen

Fields 21 & 22
Cross off the Paragraph which
DOES NOT APPLY

Fields 27 & 28
Physician Signature & Date must be
ON or AFTER Sterilization DATE