Sterilization Consent Form

Refer to Sterilization Consent Form Instructions document on TMHP.com to complete this form accurately.

Fax completed form to (512) 514-4229

* *Indicates required field*

** *Indicates a field required under certain conditions*

Optional: This free space is intended for provider/facility use ONLY (*TMHP will not use information entered in this field for processing)*:

Client Information

1. Client Medicaid or HHSC Client Number:	2. Date Client Signed (mm/dd/yyyy):

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 _____ (*3. 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 _____ (*4. specify type of operation). 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 _____ (*5. client's date of birth, mm/dd/yyyy). I, _____ (*6. client's full name), hereby consent of my own free will to be sterilized by _____ (*7. doctor or clinic) by a method called _____ _____ (*8. specify type of operation).

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.

X_____	_____
*9. Client's Signature	*10. Date of Signature (mm/dd/yyyy)

Sterilization Consent Form

Race and Ethnicity Designation (You are requested to supply the following information, but it is not required.)

11. Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

12. 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 (Do NOT complete this section if an interpreter is not required. If an interpreter is required to ensure the client understands the intent of the form and the services to be provided, this section must be completed.)

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in the _____ language (13. client's primary language) and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

X _____	_____
**14. Interpreter's Signature	**15. Date of Signature (mm/dd/yyyy)

Statement of Person Obtaining Consent

Before _____ (*16. client's full name) signed the consent form, I explained to him/her the nature of the sterilization operation _____(*17. 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 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.

X _____	_____
*18. Signature of Person Obtaining Consent	*19. Date of Signature (mm/dd/yyyy)

*20. Facility Name:	*21. Facility Address:

Sterilization Consent Form

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (*22. name of individual to be sterilized), on_____ (*23. date of sterilization), I explained to him/her the nature of the sterilization operation _____(*24. 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.

***25. Choose one of the two statements below as applicable:**

☐ (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. (Note: Use this option 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.)

☐ (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 one of the following circumstances.

****26. If you chose option #2, check the applicable box below and fill in the information requested:**

☐ (a) Premature delivery - Individual's expected date of delivery (**26a. [mm/dd/yyyy]):
_____

☐ (b) Emergency abdominal surgery (**26b. describe circumstances):_____

*X*_____	_____
*27. Physician's Signature	*28. Date of Signature (mm/dd/yyyy)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Form Processing and Provider Contact Information

29. Provider Tax ID:		*30. NPI:	
*31. Taxonomy:		32. Provider/Clinic Phone:	
*33. Provider/Clinic Fax:		34: Benefit Code:	
35. Address	City:	State:	ZIP + 4: