Sterilization Consent Form

Patient Consent
Name: _____ Phone: _____
Address: _____
ID No.: _____ Chart No.: _____
I, the undersigned…
☐ Verify that I am over _____ years of age.
☐ Understand the pain, discomfort, risks, benefits and recovery time associated with this procedure.
☐ Understand that this procedure is irreversible and permanent.
☐ Understand that after this procedure I will be unable to conceive, bear or father children.
☐ Have been informed of other birth control options, including _____
☐ Have rejected the aforementioned temporary options and have chosen sterilization.
☐ Understand that I have _____ days until the surgery and that I can revoke my consent at any time without penalty or loss of benefits
☐ Will undergo the procedure _____ for the purpose of sterilization.
☐ Verify that the doctor has explained the aforementioned information to me in detail and has answered all questions I had.

_____ _____

Patient Signature **Date**

Physician Statement
Doctor Name: _____ Hospital: _____
Operating Surgeon Name: _____
I, the consulting physician…
☐ Hereby state that to the best of my knowledge, the patient is over _____ years of age, mentally sound and physically capable of undergoing the surgery.
☐ Explained the resulting benefits, risks, pain and discomfort of this procedure to the patient.
☐ Believe that the patient understands that the procedure will result in permanent, irreversible sterility.
☐ Ensured that the patient voluntarily consented to this operation and understands that consent can be revoked at any time.
☐ Understand that I must wait _____ days before ordering the procedure unless the patient either goes into premature labor or has emergency abdominal surgery.
☐ Will refer the patient to _____ for the purpose of the sterilization procedure.
☐ Swear that I have explained the aforementioned information to the patient in detail and have answered all questions asked.

_____ _____

Physician Signature **Date**

Witness Statement
I, _____ , hereby swear and confirm that I witnessed the physician inform the patient of the aforementioned information and that the witness did sign the document in his or her own hand.

_____ _____

Witness Signature **Date**