

# Consent for Sterilization

## Patient Information

- Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Address: \_\_\_\_\_

## Acknowledgment of Procedure

I, \_\_\_\_\_ (patient name), voluntarily consent to undergo a sterilization procedure known as:

\_\_\_\_\_ (specify type of procedure, e.g., tubal ligation, vasectomy).

I understand the following:

1. The procedure is intended to permanently prevent pregnancy and is irreversible.
2. I have been informed about the risks, benefits, and alternatives to sterilization, including temporary birth control methods.
3. I have had the opportunity to ask questions and receive answers to my satisfaction.

## Voluntary Consent

I confirm that I am making this decision voluntarily and without coercion or pressure from any individual or organization.

I understand that I can withdraw my consent at any time before the procedure without any impact on my access to medical care or other services.

## Signatures

- Patient Signature: \_\_\_\_\_
- Date: \_\_\_\_\_

## Physician Certification

I certify that I have explained the nature and consequences of the sterilization procedure to the patient and provided information about alternative methods of contraception.

- Physician Name: \_\_\_\_\_
- Physician Signature: \_\_\_\_\_
- Date: \_\_\_\_\_

## Optional Witness (if applicable)

I confirm that I witnessed the patient signing this consent form voluntarily.

- Witness Name: \_\_\_\_\_
- Witness Signature: \_\_\_\_\_

- Date: \_\_\_\_\_