B.4.15 Hysterectomy and Sterilization Procedures and Consent Forms

HYSTERECTOMY RECEIPT OF INFORMATION FORM FD-189

Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189). Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involving hysterectomy procedures must have a properly completed FD-189 attached when submitted for payment. Hysterectomy claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing hysterectomy procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with your manual.

Providers may obtain additional copies of the FD-189 form from the Fiscal Agent; however, photocopies of the FD-189 are acceptable.

A sample of the Hysterectomy Receipt of Information Form and instructions for the form's proper completion are included for reference.

State of New Jersey
Department of Human Services
Division of Medical Assistance
and Health Services

HYSTERECTOMY RECEIPT OF INFORMATION FORM

An individual who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information orally and in writing from _____
name of clinic or
_____ before my operation was performed.
physician

I talked to _____ about a hysterectomy. _____
name of responsible person(s) *she/he/they*
discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _____ of _____ and that
name of staff member *clinic/hospital/physician*
all my questions were answered to my satisfaction.

I, _____, hereby consent (or did consent) of my own free
name of recipient
will to have a hysterectomy done by _____ and/or
physician
associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department but only for purposes of determining if Federal laws were observed.

_____ _____
Recipient's Signature **Date: Month/Day/Year**

FD-189 (Rev 7/83) 7472 M ED 7/83

Item-By-Item Instructions for Completing the
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)

1) ***Name of Clinic or Physician:*** Enter the name of the clinic or physician who provided the information.

2) ***Name of Responsible Person(s):*** Enter the name of the individual who discussed the procedure with the recipient.

3) ***She/He/They:*** Enter appropriate selection.

4) ***Name of Staff Member:*** Enter the name of the individual who explained the procedure to the recipient.

5) ***Clinic/Hospital/Physician:*** Enter the name of the clinic/hospital or physician's office in which the individual who explained the procedure is affiliated.

6) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

7) ***Name of Physician:*** Enter the physician's name.

8) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date the completed form.

Consent Form – 7473 M ED

Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form prior to the sterilization of an individual.

The Consent Form is a replica of the form contained in the Federal Regulations and must be utilized by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involved in a sterilization procedure must have a properly completed Consent Form attached when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing sterilization procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with you manual.

Providers may obtain additional copies of the Consent Form from the Fiscal Agent; however, photocopies of the Consent Form are acceptable.

A sample of the Consent Form and instructions for the form's proper completion are provided for reference.

CONSENT FORM

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 RECEIVEING FEDERAL FUNDS.

CONSENT TO STERILIZATION

*** PERSON OBTAINING CONSENT**

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 AFDC 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 CHILREN.

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
specify type of operation
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 thirty (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.

STATEMENT OF

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
recipient
sterilized by _____ by a method called
doctor
_____. 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, Education, and Welfare or Employees of programs or projects funded by that Department, but only for determining if Federal laws were observed.

_____ Date: _____
signature *month/day/year*

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

[ ] American Indian or Alaska Native	[ ] Black (not of Hispanic origin)
[ ] Asian or Pacific Islander	[ ] Hispanic
	[ ] White (not of Hispanic origin)

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.

_____ Date: _____
interpreter *month/day/year*

7473-M ED 3/81

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 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.

_____ Date: _____
signature of person obtaining consent *month/day/year*

_____
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 _____, the fact that it is intended to be a final and irreversible
specify type of operation
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 thirty (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 that is not used.)

1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
2) This sterilization was performed less than thirty (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 deliver
   [ ] Individual's expected date of delivery:
   [ ] Emergency abdominal surgery:
   (describe circumstances);

_____ Date: _____
physician *month/day/year*

Item-By-Item Instructions for Completing the
Sterilization Consent Form Section 1 Consent to Sterilization

1) ***Doctor or Clinic:*** Enter the name of the physician or clinic.

2) ***Sterilization Procedure:*** Enter the name of the sterilization procedure.

3) ***Recipient's Date of Birth:*** Enter recipient's date of birth in month, day, and year sequence (mm/dd/yy).

4) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

5) ***Doctor:*** Enter physician's name who is performing the procedure

6) ***Type of Sterilization:*** Enter the method of sterilization chosen.

7) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date form at least thirty (30) days, but not more than 180 days prior to surgery.

Section II Race and Ethnicity Designation:

8) ***Race and Ethnicity Designation:*** OPTIONAL INFORMATION requested by the Federal Government, but is NOT required.

Section III Interpreter's Statement: *To be used only when the Recipient does not speak English*

9) ***Language Used:*** Enter language used.

10) ***Interpreter's Signature:*** Interpreter must sign and date form at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

Section IV Statement of Person Obtaining Consent

11) ***Name of Individual:*** Enter the name of the recipient as it appears in Section I, item 4.

12) ***Sterilization/Operation:*** Enter the name of the sterilization procedure.

13) ***Signature of Person Obtaining Consent:*** Signature and date of the person who explains the procedure to the recipient and obtains the recipient's consent. Must be completed at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

14) ***Facility's* Name and Address:** Enter the name and address of the facility or physician's office with which the person obtaining the consent is affiliated.

15) ***Name of Individual to be Sterilized:*** Enter the recipient's name as it appears in Section I, item 4.

16) ***Date of Sterilization*****:** Enter the date of the sterilization in month, day, and year sequence (mm/dd/yy).

17) ***Specify Type of Operation:*** Enter the name of the sterilization procedure.

18) ***Paragraphs 1) and 2):*** The physician must indicate the paragraph that applies to recipient's situation. Paragraph 1) states that at least thirty (30) days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. Paragraph 2) states that the sterilization was performed less than thirty (30) days, but more than 72 hours after the date of the individual's signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

19) ***Physician's Signature and Date:*** Physician must sign and date form after the surgery has been performed.