

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 _____ . 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 rights to future care or treatment. I will not lose any help or benefits from _____ A.F.D.C. or Medicaid that I am now receiving.

I UNDERSTAND THAT I WILL BE STERILIZED BY _____ **Bilateral Tubal Ligation** AND THAT I DO NOT WANT TO BE STERILIZED BY ANY OTHER METHOD. I AM NOT BEING CONSIDERED A CHILD AND I DO NOT WANT TO BE STERILIZED FOR MY OTHER 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 _____ **Bilateral Tubal Ligation** _____ .

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 do not want the operation to be done until at least thirty days after change my mind at any time and that my decision will not result in the withholding of any federal funded programs.

I am at least 21 years of age and was born on 3 / / _____ .

I, 4 _____ , _____ .

_____ .

hereby consent of my own free will to be sterilized by _____ **Bilateral Tubal Ligation** _____ by a _____ .

method called _____ **Bilateral Tubal Ligation** _____ .

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 _____ **Penny L. Sillen,** _____ 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 _____

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 12 _____ **Penny L. Sillen,** _____ signed the consent form, I explained to _____ 13 _____ **Bilateral Tubal Ligation** _____ operation _____ 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 consequences of the procedure.

14 _____ Date: 15 / / _____ .

Signature of person obtaining consent _____ Mo Day Yr _____

Name of Facility where patient was counseled _____ 17 _____

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

■ PHYSICIAN'S STATEMENT ■

Shortly before _____ 18 _____ **Penny L. Sillen,** _____ in operation upon _____ 19 _____ on _____ .

I explained to him/her the nature of the sterilization operation _____ 20 _____ **Bilateral Tubal Ligation** _____ .

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 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.

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

(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.)

_____ 27 _____ **Marcus J. Welby M.D.** _____ Date: 28 / / _____ .

Signature of Physician performing surgery _____ Mo Day Yr _____

_____ 27 _____ **Marcus J. Welby M.D.** _____ Date: 28 / / _____ .

Signature of Physician performing surgery _____ Mo Day Yr _____