HYSTERECTOMY ACKNOWLEDGMENT OF CONSENT

Complete **PART A** if consent is obtained **PRIOR** to surgery

It is anticipated that _____ will perform a hysterectomy on me. I understand that there are medical indications for this surgery. It has been explained to me and I understand that this hysterectomy will render me permanently incapable of bearing children.

Diagnosis: _____

Signature of Patient: _____ Date: _____

Signature of Person
Explaining Hysterectomy: _____ Date: _____

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Complete **PART B** if consent is obtained **AFTER** surgery

On _____
(Date) (Physician)
performed a hysterectomy on me. I understand that there were medical indications for this surgery. Prior to the procedure the doctor again explained to me that this surgery would render me permanently incapable of bearing children.

Diagnosis: _____

Signature of Patient: _____ Date: _____

Signature of Person
Explaining Hysterectomy: _____ Date: _____

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COMPLETE **PART C** IF NO CONSENT IS OBTAINED

Diagnosis: _____

Check which is applicable:

[ ] Other reason for sterility: _____

[ ] Previous tubal Date: _____

[ ] Emergency situation (describe)

_____

_____

_____

_____
Physician Signature Date