LDSS-3113 (4/84)

ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

(NYS MEDICAID PROGRAM)

EITHER PART I OR PART II MUST BE COMPLETED

RECIPIENT ID NO.	SURGEON'S NAME

PART I: RECIPIENT'S ACKNOWLEDGMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGMENT STATEMENT

It has been explained to me, _____ , that the hysterectomy to be performed on me
(RECIPIENT NAME)
will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me and all my questions have been answered to my satisfaction prior to the surgery.

RECIPIENT OR REPRESENTATIVE SIGNATURE	DATE	INTERPRETER'S SIGNATURE (If required)	DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

SURGEON'S SIGNATURE	DATE
X	

PART II: WAIVER OF ACKNOWLEDGMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on _____ was solely for medical indications.
(RECIPIENT NAME)
The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

☐ 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility) _____

_____

☐ 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgment was not possible. (briefly describe the nature of the emergency)

_____

_____

☐ 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

SURGEON'S SIGNATURE	DATE
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient.