MAP-251
(Rev. 07/2023)

Commonwealth of Kentucky
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

HYSTERECTOMY CONSENT FORM

Medicaid Patient Name _____ Medicaid ID # _____

Physician's Name _____ Date of Hysterectomy _____

>>>>Complete Sections A and B or Section C. The physician signature is required in Section B or C.<<<<

SECTION A: COMPLETE THIS SECTION FOR PATIENT WHO ACKNOWLEDGES RECIEPT PRIOR TO HYSTERECTOMY

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF REPRODUCING.

_____

Patient's Signature DATE

_____

WITNESS' SIGNATURE DATE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE. CHECK ONLY ONE SELECTION.

I certify that before I performed the hysterectomy procedure on the patient listed below:

1 [ ] I informed the patient that this operation would make the patient permanently incapable of reproducing.

2 [ ] **This certification for retroactively eligible patient only** – a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made.

3 [ ] Patient was already sterile due to _____

_____

CAUSE OF STERLITY

4 [ ] Patient had a hysterectomy performed because of a life-threatening situation due to _____

_____

DESCRIBE EMERGENCY SITUATION

And the information concerning sterility could not be given prior to the hysterectomy. Life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement.

_____

PHYSICIAN'S SIGNATURE DATE

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT PATIENT ONLY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above patient, it will render the patient permanently incapable of reproducing.

_____ _____

WITNESS' SIGNATURE DATE PATIENT REPRESENTATIVE SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above patient was medically necessary due to _____

_____

REASON FOR HYSTERECTOMY

And was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on the patient I counseled the patient representative, orally and in writing that the hysterectomy would render that individual permanently incapable of reproducing; and the individual's representative has signed a written acknowledgement of receipt of the foregoing information.

_____

PHYSICIAN'S SIGNATURE DATE