FORM 4-3

Authorization for and Consent to Hysterectomy

Patient Name: ______________________________

1. This form is called an "informed consent form." Its purpose is to inform you about the hysterectomy procedure you are considering. You should read the form carefully and ask any questions you may have before you decide whether or not to give your consent to the hysterectomy.
2. All operations involve risks of unsuccessful results, complications, injury, or even death, sometimes for reasons that we are unable to anticipate or foresee. Therefore, no guarantee can be made as to the results of the operation.
3. You have the right to be informed of the discomforts and risks that may accompany or follow the hysterectomy, including the type and possible effects of any anesthetic to be used.
4. You have the right to be informed whether your physician has any medical research or economic interests related to the performance of the proposed operation(s) or procedure(s). You also have the right to be informed of the expected benefits of the procedure and the available alternative methods of treatment and their risks and benefits.
5. You have the right to consult a second physician before having the hysterectomy.
6. You have the right to withhold or withdraw your consent to the hysterectomy at any time before it is performed. Your withdrawal of consent shall not affect your right to future care or treatment or result in the loss or withdrawal of any state or federally funded program benefits to which you might otherwise be entitled.
7. The following information concerning the proposed hysterectomy must be provided to you, *verbally* and *in writing*, by your physician [attach written information to this form]:
   a. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.
   b. Advice that the hysterectomy procedure is considered irreversible and that, unless you are already sterile or postmenopausal, it will result in permanent infertility.
   c. A description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
   d. A description of the benefits or advantages that may be expected as a result of the hysterectomy.
   e. The approximate length of the hospital stay.
   f. The approximate length of time for recovery.
   g. The financial cost to you of the physician's and surgeon's fees.
8. The hysterectomy procedure will be performed at *(hospital name)* ______________________________ ______________________________. The hospital maintains personnel and facilities to assist your physician in the performance of the procedure. Your physician is not an employee or agent of the hospital named above. He or she is an independent medical practitioner.

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9. Upon your authorization and consent, the hysterectomy described above will be performed on you, together with any different or further procedures which, in the opinion of your physician, may be indicated due to any emergency. The hysterectomy will be performed by *(physician name)* ______________________________ (or in the event that he/she is unable to perform or complete the procedure, a qualified substitute physician or surgeon) together with associates and assistance from the medical staff of *(hospital name)* _______________________________________ to whom your physician may designate responsibilities. The physicians are not employees or agents of the hospital named above. They are independent medical practitioners.

10. The persons in attendance for the purpose of performing specialized medical services (such as anesthesiology, radiology or pathology) are not employees or agents of the hospital or of your physician. They are independent medical practitioners.

11. By your signature below, you authorize the pathologist to use his or her discretion in the disposition or use of any organ, member or other tissue taken from your body during the hysterectomy.

12. To make sure that you fully understand the information contained in this informed consent form, your physician will discuss the information with you after you have had a chance to read it and before you decide whether or not to give consent. If you have any questions you are encouraged and expected to ask them. If you think of any questions later, contact [insert name, phone number and address of physician]:______________________________
____.

13. You are making a decision whether or not to consent to a hysterectomy. Your signature on this informed consent form indicates that: (a) you have read and understood the information provided in this form, (b) you have been verbally informed about this procedure, (c) you have had a chance to ask questions, (d) you have received all of the information you want concerning the procedure, and (e) you authorize and consent to the performance of the hysterectomy.

Date: ____________________________ Time: ____________________________ AM / PM

Signature: ____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: ________________________

Print name: ____
(legal representative)

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Physician Certification

I, the undersigned physician, hereby certify that I have discussed the hysterectomy procedure with this patient, including the risks and benefits of the procedure, any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable and any research or economic interest I may have regarding this treatment. As required by Health and Safety Code Section 1690, I have given to the patient, both verbally and in writing, the information described in Paragraph 6 of this consent form. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: ______________________________ Time: ______________________________ AM / PM

Signature: ____
(physician)

Print name: ____

ALL PATIENTS:
Copy to Patient and Original to Medical Record

MEDI-CAL AND CERTAIN OTHER FEDERALLY FUNDED PATIENTS:
A copy should also accompany claims submitted for services funded by Medi-Cal or certain other federal sources. If the patient is already sterile, the informed consent form need not accompany a Medi-Cal claim; however, the physician must submit a handwritten and signed statement explaining the previous sterility.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Sections 1690, 1691; Title 22, California Code of Regulations, Section 70707.5; CMS Hospital *Interpretive Guidelines*, A-0466

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