

HEALTH FIRST COLORADO (Colorado's Medicaid Program)
STERILIZATION CONSENT FORM (MED-178)

Member's Health First Colorado ID: \_\_\_\_\_

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 \_\_\_\_\_ When I first asked for the

1. Health Care Provider or Clinic

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 right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER 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 an operation know as a \_\_\_\_\_

2. Type of Procedure

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: \_\_\_\_\_

3. Date of Birth

I, \_\_\_\_\_, hereby consent of my own

4. Name of Member

free will to be sterilized by \_\_\_\_\_ by a

5. Health Care Provider or Clinic

method called \_\_\_\_\_ My consent

6. Type of Procedure

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 U.S. Department of Health and Human Services, or employees of programs or projects funded by the Department but only for determining if federal laws were observed.

I have received a copy of this form.

7. Member's Signature

8. Date of Signature

You are requested to supply the following information, but it is not required: (9. Ethnicity and Race)

Ethnicity:

- Hispanic or Latino
Not Hispanic or Latino

Race:

- American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

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 read to the member this consent form in \_\_\_\_\_

10. Language

language and explained its contents to the member. To the best of my knowledge and belief, the member has understood this explanation.

11. Interpreter's Signature

12. Date of Signature

STATEMENT OF PERSON OBTAINING CONSENT

Before \_\_\_\_\_ signed the consent form,

13. Name of Member

I explained to member the nature of the sterilization operation \_\_\_\_\_, the fact that it is intended to be a

14. Type of Procedure

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 that member consent can be withdrawn at any time and that the member 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. Member knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

15. Signature of Person Obtaining Consent

16. Date of Signature

17. Name of Facility Where Information About Sterilization Was Given to Member

Address of Facility (including city, state, and zip code)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon \_\_\_\_\_ on \_\_\_\_\_

18. Name of Member

19. Date of Procedure

I explained to the individual the nature of the sterilization operation known as \_\_\_\_\_, the fact

20. Type of Procedure

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 member consent can be withdrawn at any time and that the member will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old ad appears mentally competent. Member knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where 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 that is not used.)

21.(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization procedure was performed.

21.(2) The 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 and fill in information requested):

- a. Premature delivery. Expected date of delivery: \_\_\_\_\_
b. Emergency abdominal surgery (describe circumstances): \_\_\_\_\_

22. Signature of Person Who Performed Procedure

23. Date of Signature

24. **If** an individual practitioner's name is listed in Field 5 (rather than a group or clinic name) and that practitioner's name is different from the signature in Field 22, this is because:

- A different practitioner was on call at the time of the procedure
- A different practitioner in the same practice performed the procedure
- Other (please explain: \_\_\_\_\_)

**Federal Paperwork Reduction Act Statement  
(OMB No. 0937-0166)**

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.