Wyoming Department of Health

Hysterectomy Acknowledgment of Consent Form

Member Name _____ **Member ID** _____

Provider Name _____ **NPI/Provider Number** _____

PART A

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

It is anticipated that _____ (Physician) 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 _____

Member Signature _____ **Date** _____

Signature of Person Explaining Hysterectomy _____ **Date** _____

PART B

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

On _____ (mm/dd/yyyy), _____ (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 _____

Member Signature _____ **Date** _____

Signature of Person Explaining Hysterectomy _____ **Date** _____

PART C

Complete **PART C** if NO consent is obtained.

Diagnosis _____

Check which is applicable:

- ☐ Other reason for sterility _____
- ☐ Previous tubal Date (*mm/dd/yyyy*) _____
- ☐ Emergency situation (*describe*)

WYBMS-Hysterectomy Consent

Physician Signature _____ **Date** _____