STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Acknowledgement of Receipt of Hysterectomy Information

The Form is provided to meet the 42 CFR §441.2455 (c)(1)(2) Sterilization by hysterectomy and OAC: 317:30-5-19 Hysterectomies

Patient Name: _____

Address: _____

_____

Telephone #: _____

OHCA/Medicaid #: _____

Physician: _____

Address: _____

_____

_____

* * *

Prior to surgery, I have been informed, both orally and in writing, that as a result of the hysterectomy, which is to be performed by the doctor named above, I will be permanently incapable of reproduction.

_____
Patient Signature

_____
Date