

### 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**