HYSTERECTOMY - INFORMED CONSENT

This is to certify that I, ______________________________, have been advised by my
(name of patient)
physician or his or her designee, ______________________________________, that the
(name of physician/designee)
hysterectomy which will be performed on me will render me permanently sterile and incapable of having children. I have been informed of my rights to consultation by a second physician prior to having this operation.

____ ____________________
Patient Signature Date

____ ____________________
Patient Representative Date
(if any)

Prepare in triplicate: copy to patient; copy to patient records; copy to physician billing form.