HYSTERECTOMY NECESSITY

To be completed by the individual receiving the hysterectomy or her representative, if any:

_____.

(Please print name and relation to patient.)

Please select one of the following choices and place your initials on the line next to the statement that best describes your situation.

____Prior to surgery, I received, orally and in writing, information stating that the hysterectomy would render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

___ I am already sterile and incapable of bearing children. My physician and I have orally discussed my illness, and he or she has given me written information on my illness that has led to the decision for this surgery. The illness/disease/symptoms that I have is called:

_____.

_____ _____

(Signature of Patient or Representative) (Date 00/00/0000)

_____ _____

(Signature of Physician) (Date 00/00/0000)