# Hysterectomy Receipt of Information Form

**State of New Jersey**
**Department of Human Services**
**Division of Medical Assistance and Health Services**

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You cannot have a baby after your uterus is removed, and you will not have menstrual periods anymore.

I received the above information orally and in writing from _____
*Name of clinic or physician*

before my operation was performed.

I talked to _____ about a hysterectomy._____
*Name of responsible person(s)* *She/he/they*

discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _____ of _____ and that
*Name of staff member* *Clinic/hospital/physician*

all my questions were answered to my satisfaction.

I, _____, hereby consent or did consent of my own free will to have
*Name of recipient*

a hysterectomy done by _____ and/or associates or assistants
*Physician*

of his or her choice.

I consent or did consent to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to the representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that department, <u>but only for</u> purposes of determining if federal laws were observed.

_____

**Recipient's signature** **Date: Month/Day/Year**

**Item-by-item Instructions for Completing the**
**Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)**

1) ***Name of Clinic or Physician:*** Enter the name of the clinic or physician who provided the information.

2) ***Name of Responsible Persons:*** Enter the name of the individual who discussed the procedure with the recipient.

3) ***She/He/They:*** Enter appropriate selection.

4) ***Name of Staff Member:*** Enter the name of the individual who explained the procedure to the recipient.

5) ***Clinic/Hospital/Physician:*** Enter the name of the clinic/hospital or physician's office in which the individual who explained the procedure is affiliated.

6) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Eligibility Identification Card. First name must be entered first.

7) ***Name of Physician:*** Enter the physician's name.

8) ***Recipient's Signature and Date:*** Recipient must personally sign and date the completed form.