ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART I - (MUST BE COMPLETED)

Recipient Name ________________________________________________________________________________
Recipient Identification No. ________________________________________________________________________
Physician Name _________________________________________    Provider No. ___________________________

PART II - ACKNOWLEDGEMENT

It has been explained to _______________________________________ and the patient’s representative, if any, orally and in writing that the hysterectomy to be performed on the patient will render the patient permanently incapable of reproducing.

_____________________________________________   ______________________________________
Recipient or Representative Signature                                   Date

(If required, Interpreter Signature)                                   Date

PART III - PHYSICIAN STATEMENT

In my professional judgment, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

_____________________________________________   ______________________________________
Physician Signature                                             Date

PART IV - EXCEPTION REQUEST

- **Exception 1** - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was __________________________________________.
- **Exception 2** - I certify that the hysterectomy performed on the above named individual was performed under a life threatening emergency situation, i.e., __________________________________________, in which I determined prior acknowledgment of receipt of hysterectomy information was not possible. I have attached a copy of the hospital operative record or other written explanation as to the nature of the emergency.
- **Exception 3** - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery ______________________________

I certify that the above named individual was informed prior to the operation that the hysterectomy would render the patient permanently incapable of reproducing; or that Exception 1 ( ) or Exception 2 ( ), as certified above, made such explanation unnecessary or impossible.

_______________________________________________  ______________________________________
Physician Signature                                           Date

Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form approved by the Forms Management Center.