



CONSENT TO OPERATIVE PROCEDURES

- 1. I hereby authorize Dr. Vikas Merchia and associates...
2. I impose no specific limitations or prohibitions regarding treatment...
3. If any conditions are found at the time of operation...
4. The nature, extent and purpose of the operation...
5. Anesthesia will be given by or under the direction of the Anesthesia Staff.
6. I consent to have the pathologist perform such examination of specimens...
7. I consent to the televising, videotaping and/or photographing of the operation(s)...
8. I consent to the presence of a clinical consultant/observer upon the request/permission of the surgeon.
9. The possible need for a transfusion of blood and/or blood components...
10. Surgeon's comments, if any: Major RISKS including, but not limited to: Bleeding (possibly requiring transfusion); Infection; Injury to surrounding structures...

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT THE SURGEON, OR HIS/HER DESIGNEE HAS ANSWERED ALL OF MY QUESTIONS.

I CERTIFY THAT I HAVE CONVEYED THE RISKS AND BENEFITS OF THE PROCEDURE, AS DESCRIBED BY THE PHYSICIAN, TO THE BEST OF MY ABILITY.

Signature of Surgeon/Designee Date Time

Signature of Translator Date Time

Signature of Patient/Designee Date Time

Witness Date Time

If patient is unable to sign or is under 18 years of age, complete the following:

Patient is a minor years of age.

Patient is unable to sign because:

I am of patient, and hereby consent to the surgical procedure(s) on behalf of the patient:



**Commonwealth of Massachusetts
Executive Office of Health
and Human Services**

600 Washington Street
Boston, MA 02111

Name of Patient: _____
(please print)

HYSTERECTOMY INFORMATION FORM

Instructions to Providers — Each provider requesting payment for any portion of a hysterectomy must attach a completed HI-1 form to the claim form. When more than one provider is requesting payment for the same hysterectomy, a photocopy of the completed form may be submitted in lieu of the original.

A. HYSTERECTOMY INFORMATION

A hysterectomy is an operation in which a woman's uterus (womb) is removed. A hysterectomy should be done only when there is a disease or injury of the uterus (or some other medical problem) that can only be treated by removing the uterus. Your doctor should explain to you why a hysterectomy is needed and what discomforts, risks, and benefits may result from the surgery.

If you have a hysterectomy, you cannot become pregnant or bear children. A hysterectomy is permanent and cannot be reversed.

If the reason you are having a hysterectomy is to avoid bearing children, you should consider other methods of sterilization, such as tubal ligation (having your tubes tied). **MassHealth will not pay for a hysterectomy if the purpose is for birth control.** A hysterectomy takes much longer to do than a tubal ligation, and you would be in the hospital longer. There is more discomfort and a greater chance of serious health problems with a hysterectomy.

B. ACKNOWLEDGEMENT THAT HYSTERECTOMY INFORMATION WAS RECEIVED

Federal regulations (42 CFR 441.255) require that a MassHealth member having a hysterectomy sign written acknowledgement that information about hysterectomies was received before the operation was performed.

Acknowledgement That Hysterectomy Information Was Received

I have read the above information about the hysterectomy operation. A medical person has also explained hysterectomies to me. The discomfort, risks, and benefits that go along with a hysterectomy have been explained to me. All of my questions have been answered to my satisfaction.

I understand that if I have a hysterectomy operation I cannot become pregnant or bear children. I understand that a hysterectomy is permanent and cannot be reversed.

Signature of Member or Representative: _____

Date: _____ Relationship of Representative to Member: _____