FORM 4-3

Authorization for and Consent to Hysterectomy

Patient Name: ______________________________

1. This form is called an "informed consent form." Its purpose is to inform you about the hysterectomy procedure you are considering. You should read the form carefully and ask any questions you may have before you decide whether or not to give your consent to the hysterectomy.
2. All operations involve risks of unsuccessful results, complications, injury, or even death, sometimes for reasons that we are unable to anticipate or foresee. Therefore, no guarantee can be made as to the results of the operation.
3. You have the right to be informed of the discomforts and risks that may accompany or follow the hysterectomy, including the type and possible effects of any anesthetic to be used.
4. You have the right to be informed whether your physician has any medical research or economic interests related to the performance of the proposed operation(s) or procedure(s). You also have the right to be informed of the expected benefits of the procedure and the available alternative methods of treatment and their risks and benefits.
5. You have the right to consult a second physician before having the hysterectomy.
6. You have the right to withhold or withdraw your consent to the hysterectomy at any time before it is performed. Your withdrawal of consent shall not affect your right to future care or treatment or result in the loss or withdrawal of any state or federally funded program benefits to which you might otherwise be entitled.
7. The following information concerning the proposed hysterectomy must be provided to you, *verbally* and *in writing*, by your physician [attach written information to this form]:
   a. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.
   b. Advice that the hysterectomy procedure is considered irreversible and that, unless you are already sterile or postmenopausal, it will result in permanent infertility.
   c. A description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
   d. A description of the benefits or advantages that may be expected as a result of the hysterectomy.
   e. The approximate length of the hospital stay.
   f. The approximate length of time for recovery.
   g. The financial cost to you of the physician's and surgeon's fees.
8. The hysterectomy procedure will be performed at *(hospital name)* ______________________________ ______________________________. The hospital maintains personnel and facilities to assist your physician in the performance of the procedure. Your physician is not an employee or agent of the hospital named above. He or she is an independent medical practitioner.

9. Upon your authorization and consent, the hysterectomy described above will be performed on you, together with any different or further procedures which, in the opinion of your physician, may be indicated due to any emergency. The hysterectomy will be performed by *(physician name)* ______________________________ (or in the event that he/she is unable to perform or complete the procedure, a qualified substitute physician or surgeon) together with associates and assistance from the medical staff of *(hospital name)* ______________________________. to whom your physician may designate responsibilities. The physicians are not employees or agents of the hospital named above. They are independent medical practitioners.

10. The persons in attendance for the purpose of performing specialized medical services (such as anesthesiology, radiology or pathology) are not employees or agents of the hospital or of your physician. They are independent medical practitioners.

11. By your signature below, you authorize the pathologist to use his or her discretion in the disposition or use of any organ, member or other tissue taken from your body during the hysterectomy.

12. To make sure that you fully understand the information contained in this informed consent form, your physician will discuss the information with you after you have had a chance to read it and before you decide whether or not to give consent. If you have any questions you are encouraged and expected to ask them. If you think of any questions later, contact [insert name, phone number and address of physician]: ______________________________
______________________________.

13. You are making a decision whether or not to consent to a hysterectomy. Your signature on this informed consent form indicates that: (a) you have read and understood the information provided in this form, (b) you have been verbally informed about this procedure, (c) you have had a chance to ask questions, (d) you have received all of the information you want concerning the procedure, and (e) you authorize and consent to the performance of the hysterectomy.

Date: ______________________________ Time: ______________________________ AM / PM

Signature: ______________________________
(patient/legal representative)

If signed by someone other than patient, indicate relationship: ______________________________

Print name: ______________________________
(legal representative)

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Physician Certification

I, the undersigned physician, hereby certify that I have discussed the hysterectomy procedure with this patient, including the risks and benefits of the procedure, any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable and any research or economic interest I may have regarding this treatment. As required by Health and Safety Code Section 1690, I have given to the patient, both verbally and in writing, the information described in Paragraph 6 of this consent form. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: ______________________ Time: ______________________ AM / PM

Signature: ____
(physician)

Print name: ____

ALL PATIENTS:
Copy to Patient and Original to Medical Record

MEDI-CAL AND CERTAIN OTHER FEDERALLY FUNDED PATIENTS:
A copy should also accompany claims submitted for services funded by Medi-Cal or certain other federal sources. If the patient is already sterile, the informed consent form need not accompany a Medi-Cal claim; however, the physician must submit a handwritten and signed statement explaining the previous sterility.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Sections 1690, 1691; Title 22, California Code of Regulations, Section 70707.5; CMS Hospital *Interpretive Guidelines*, A-0466

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FORM 4-3S

Autorizacion y Consentimiento para una Histerectomia

Nombre de la Paciente: ______________________________

1. Este formulario se llama "Formulario de Consentimiento Informado." Su propósito es informar le acerca del procedimiento de histerectomía que está considerando. Usted debe leer este formulario cuidadosamente y hacer cualquier pregunta que pueda tener antes de decidir si dar o no su consentimiento a la histerectomía.
2. Todas las operaciones involucran un riesgo de fracaso, complicaciones, lesiones o aun muerte, a veces por razones que no podemos anticipar o prever. Por lo tanto, no se puede hacer ninguna garantía en cuanto a los resultados de la histerectomía.
3. Usted tiene el derecho de ser informada acerca de las incomodidades y riesgos que pueden ocurrir durante o después de la histerectomía, incluyendo el tipo y posibles efectos de cualquier anestésico que se use.
4. Usted tiene el derecho de ser informada si su médico tiene algún interés por investigación médica o factores económicos respecto a la realización de la(s) operación(es) o procedimiento(s) que se proponen. Usted también tiene el derecho de ser informada de los beneficios que se esperan del procedimiento y los métodos alternativos de tratamiento disponibles, así como sus riesgos y beneficios.
5. Usted tiene el derecho de solicitar el consejo de un segundo médico antes de a la histerectomía.
6. Usted tiene el derecho de no dar o de retirar su consentimiento a la histerectomía en cualquier momento antes de que se efectúe. El hecho de retirar su consentimiento no afectará su derecho a atención o tratamiento futuro ni resultará en la pérdida o retiro de cualesquiera beneficios de programas subsidiados por el gobierno federal o estatal a los que, en otras circunstancias, usted tendría derecho.
7. Su médico debe proporcionarle la siguiente información en forma oral y escrita con respecto a la histerectomía propuesta [attach written information to this form]:
   a. Una descripción del tipo o los tipos de cirugía y demás procedimientos involucrados en la histerectomía que se propone, y una descripción de las alternativas a la histerectomía que estén disponibles y sean apropiadas.
   b. La advertencia que la histerectomía se considera irreversible y que, a menos que la paciente ya sea estéril o postmenopáusica, ello resultará en la infertilidad permanente.
   c. Una descripción de las incomodidades y riesgos que pueden ocurrir durante o después del procedimiento, y una descripción del tipo y los posibles efectos de cualquier anestésico que se use.
   d. Una descripción de los beneficios o ventajas que pueden esperarse como resultado de la histerectomía.
   e. La duración aproximada de la hospitalización.

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f. La duración aproximada del período de recuperación.

g. El costo que los honorarios del médico y del cirujano representan para usted.

8. La histerectomía se llevará a cabo en el *(hospital name)* ______________________________ ______________________________. El hospital mantiene el personal e instalaciones para asistir a su médico en la realización de la histerectomía. Su médico no es empleado o un agente del hospital nombrado arriba. Él o ella es un médico facultativo independiente.

9. Una vez que usted dé autorización y consentimiento, se le horá la histerectomía descrita más arriba, junto con los procedimientos distintos o adicionales que, en la opinión de su médico, puedan ser indicados debido a alguna emergencia. La histerectomía será efectuada por el *(physician name)* ______________________________ (o, en caso de que no pueda llevar a cabo o concluir la operación, un médico o cirujano sustituto capacitado) junto con asociados y ayuda del personal médico del Hospital *(hospital name)* ____________ ______________________________a quienes su médico puede asignar determinadas responsabilidades. Los médicos no son empleados o agentes del hospital nombrado arriba. Son médicos facultativos independientes.

10. Las personas que asisten con el fin de desempeñar servicios médicos especializados (como por ejemplo anestesiología, radiología o patología) no son empleados o agentes del hospital o de su médico. Son médicos facultativos independientes.

11. Al poner su firma al calce, usted autoriza al patólogo a usar su discreción en la disposición o uso de cualqueir órgano, miembro u otro tejido extraído de su cuerpo durante la histerectomía.

12. Para asegurar que usted entiende plenamente la información contenida en este formulario de consentimiento informado, su médico hablará sobre la información con usted después de que usted haya tenido la oportunidad de leerla y antes de que usted decida si da o no su consentimiento. Si tiene usted alguna pregunta, se le ruega y se espera que la haga. Si se le ocurre alguna pregunta después, comuníquese con [insert name, phone number and address of physician] ______________________________ ______________________________.

13. Usted está decidiendo si consiente o no a la realización de una histerectomía. Su firma en este formulario de consentimiento informado indica que: (a) usted ha leído y entiende la información proporcionada en este formulario, (b) usted ha sido informada oralmente acerca de este procedimiento, (c) usted ha tenido la oportunidad de hacer preguntas, (d) usted ha recibido toda la información que desea respecto al procedimiento, y (e) usted autoriza y de su consentimiento para que se efectúe la histerectomía.

Fecha: ______________________________ Hora: ____________________ AM / PM

Firma: ______________________________
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: ______________________________

Nombre en letra de imprenta: ______________________________
(representante legal)

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Physician Certification

I, the undersigned physician, hereby certify that I have discussed the hysterectomy procedure with this patient, including the risks and benefits of the procedure, any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable and any research or economic interest I may have regarding this treatment. As required by Health and Safety Code Section 1690, I have given to the patient, both verbally and in writing, the information described in Paragraph 6 of this consent form. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: ______________________________ Time: ______________________________ AM / PM

Signature: ____
(physician)

Print name: ____

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Copy to Patient and Original to Medical Record

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