RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

600 New London Avenue
Cranston, Rhode Island 02920

MEDICAL ASSISTANCE HYSTERECTOMY STATEMENT

EXPLANATION OF HYSTERECTOMY PROCEDURE

A hysterectomy means a medical procedure or operation for the purpose of removing the uterus. A result of this operation will render the individual permanently sterile.

ACKNOWLEDGEMENT

I acknowledge that I have been informed that the hysterectomy procedure I am to undergo is being performed for medical reasons other than sterilization. I understand, however, that I will be permanently incapable of becoming pregnant or bearing children. This information has been provided to me orally and in writing.

Signed _____
Patient — Date of Signature

_____
Parent/Guardian//Relative (if indicated) — Date of Signature

_____
Physician — Date of Signature

ROUTING INSTRUCTIONS

This statement must be completed and forwarded to the hospital in which the operation is to be performed prior to the date of admission. The hospital will then submit this statement together with the Medical Assistance hospital billing form and the P.S.R.O. certification form to the Rhode Island Medical Assistance Program. **A signed copy must also be provided to the patient.**In addition, it is suggested that the physician should retain a signed copy for his files.