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

HYSTERECTOMY RECEIPT OF INFORMATION FORM

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not 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

_____________________ before my operation was performed.
Physician

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, __________________________,
name of recipient

hereby consent (or did consent) of my own free will to have a hysterectomy done by

___________________________ and/or associate(s) or assistant(s) of his or her choice.
Physician

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 representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department but only for purposed 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 Person(s):*** 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 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 hand date the completed form.