I hereby authorize the performance of the following sterilization procedure upon me:

____

____

to be performed under the direction of Dr (s)

____

____

and such assistants or associates as he/she may designate.

I consent to the administration of such anesthetics as may be considered appropriate by the physicians responsible for the service.

For the purpose of advancing medical education, I consent to the admittance of qualified observers to the operating room.

I consent to the disposal by hospital authorities of any tissue or part which may be removed from me.

I understand that there are certain discomforts and risks involved in sterilization and despite care in performing the procedure, it cannot be guaranteed 100%. Although the failure rate is small (1-2%), there is the possibility of a subsequent pregnancy. The sterilization procedure to be performed upon me, however, should be considered irreversible and permanent. There are alternative methods of avoiding pregnancy which are not permanent. Risks of the sterilization procedure include, but are not limited to, bleeding, infection and damage to internal structures such as bowel, bladder, ureter and ovary.

The purpose, nature, risks of and alternatives to the procedure(s) have been explained to me to my satisfaction by the above named doctor or his/her associates, and I realize that there is no certainty or guarantee as to the results of the procedures. All of my questions have been answered to my satisfaction.

I intend to be legally bound by this consent, which I am signing voluntarily after it has been completed and after having read and fully understanding it.

I understand that all life saving procedures will be performed during the surgical procedure.

Patient__________________________ _________ _________ ____________________
(Signature) *(Date)* *(Time)* *(Witness of Signature)*

When the patient is unable to give consent:

__________________________ _______________ _______ _______ ____________________
Signature of Person Authorized To Consent for Patient *(Relationship to Patient)* *(Date)* *(Time)* *(Witness of Signature)*

PHYSICIAN'S CERTIFICATION

I hereby certify that the patient or person authorized to consent for the patient did so after having been advised orally as to the nature, purpose,benefits, risks of, alternative options (including no treatment), risks of alternative options, likelihood of achieving goals of care, potential problems that may occur, the matters referred to in the consent, and after having received answers to any questions. By signing below, I indicate that the patient or person authorized to consent fully understands what I have explained and answered.

Physician__________________________ ________________________ _______ _______
(Signature) *(Printed Name)* *(Date)* *(Time)*

CONSENT FOR STERILIZATION
(OPERATION AND ANESTHETIC)

Form INV 78978 (07/18) MR (InD)
Aztec Barcode 201187

PATIENT IDENTIFICATION