# Sterilization Request Forms

Complete sections 1 – 11 ONLY
Bottom Portion 12-21 to be completed by FPP and Providing Surgeon

SEND TO:
NM DEPT. OF HEALTH/PHD/FHB/FAMILY PLANNING PROGRAM
2040 S. PACHECO, SANTA FE, NEW MEXICO 87505
PHONE NUMBER: (505) 476-8882

Example

**FAMILY PLANNING PROGRAM STERILIZATION REQUEST FORM**

**CLIENT INFORMATION**

| 1. Name (Last, First, Middle Initial) | 2. Date of Birth | 3. Date Consent Signed | 4. Clinic Name |
|---|---|---|---|
| Smith, Betty, A. | 10/24/1988 | 8/24/2022 | Your Public Health Office |

5. Type of Procedure Requested
☑ Tubal Sterilization ☐Post Partum Tubal Sterilization ☐Vasectomy

6. Percent Pay (From current Federal Poverty Guidelines)
0%

7. Staff Name, Phone # and PHD Region
John Doe, RN
Your Phone #
Your Region

8. Priority Rating (Refer to Family Planning Protocol)
☑ Priority A
☐ Priority B
Priority Justification: Justification for priority level selected, can use protocol list

9. Client contact information (Phone # included)
Client's Phone #

10. Pay Source

- Does client have private insurance? ☐Yes ☑ No
  If yes, *STOP* and have client contact their insurance company.
- Does client have Medicaid (e.g., FP, Centennial Care MCOs)? ☐Yes ☑ No
  If yes, *STOP* and refer to any provider accepting Medicaid.
- Is client eligible for FP Medicaid? ☐Yes ☑ No
  (Eligibility for FP Medicaid: NM Resident, U.S. Citizen/approved immigrant status, income up to 235% Fed Poverty level and a Social Security Number).
  If yes, *STOP* and refer to Income Support Division.

11. I authorize the release of any medical information necessary to process this claim.
I will be responsible for related cost not previously approved. Co-pay is non-refundable.

Autorizo la liberación de cualquier información de salud necesaria para procesar mi reclamación.
Me haré responsable de cualquier costo relacionado que no haya sido aprobado previamente. El copago no es reembolsable.

CLIENT SIGNATURE: Client Betty Smith's Signature

**STATE FAMILY PLANNING OFFICE INFORMATION**

| 12. Control Number | 13. Consent Valid (30 days after signature) | 14. Status of Request ☐ Approved ☐Not Approved | |
|---|---|---|---|
| 15. Consent Expiration (180 Days after signature) | 16. Approval Date | 17. Total Amount $ | 18. Date put on pending list |

**PHYSICIAN INFORMATION (To be filled in by SURGEON)**

**AMOUNT APPROVED BY DEPT. OF HEALTH**

19. Date Procedure/Service Provided By
_____Tubal Surgery_____ $_____
Facility $
_____Anesthesiology_____ $_____
Vasectomy $

Approved By
PHD Staff

20. Accept assignment as per agreement with PHD Family Planning Program
☐ YES ☐ NO

DOH/PHD to remit payment for medical and/or other services indicated above to:

21. I certify that all services indicated were completed

Signature of Physician Date

Please leave this area blank for State FP Office use
I certify that this is true copy of the original and that payment for services has not been received

New Mexico Public Health Division – Family Planning—Sterilization Request Rev 10/22

**Section 8** pick Priority A rating for tubal ligations or Priority A or B for vasectomy.

Complete *Priority Justification*

**Priority A**

- Problems with birth control method (specify)
- High risk pregnancy (present or past) or risk of poor pregnancy outcome or significant

health risk to the mother

- Genetic problems in the family
- History of physical abuse in the family
- Substance abuse (alcohol or other drugs)
- Inability to care for more children because:

o Either of the parents have a severe medical condition

o The family already had a child with a severe medical condition

- Multiparity (greater than or equal to 4 live births)

**Priority B**

- The client's Reproductive Life Plan (RLP) is that they don't want to have any (more) children

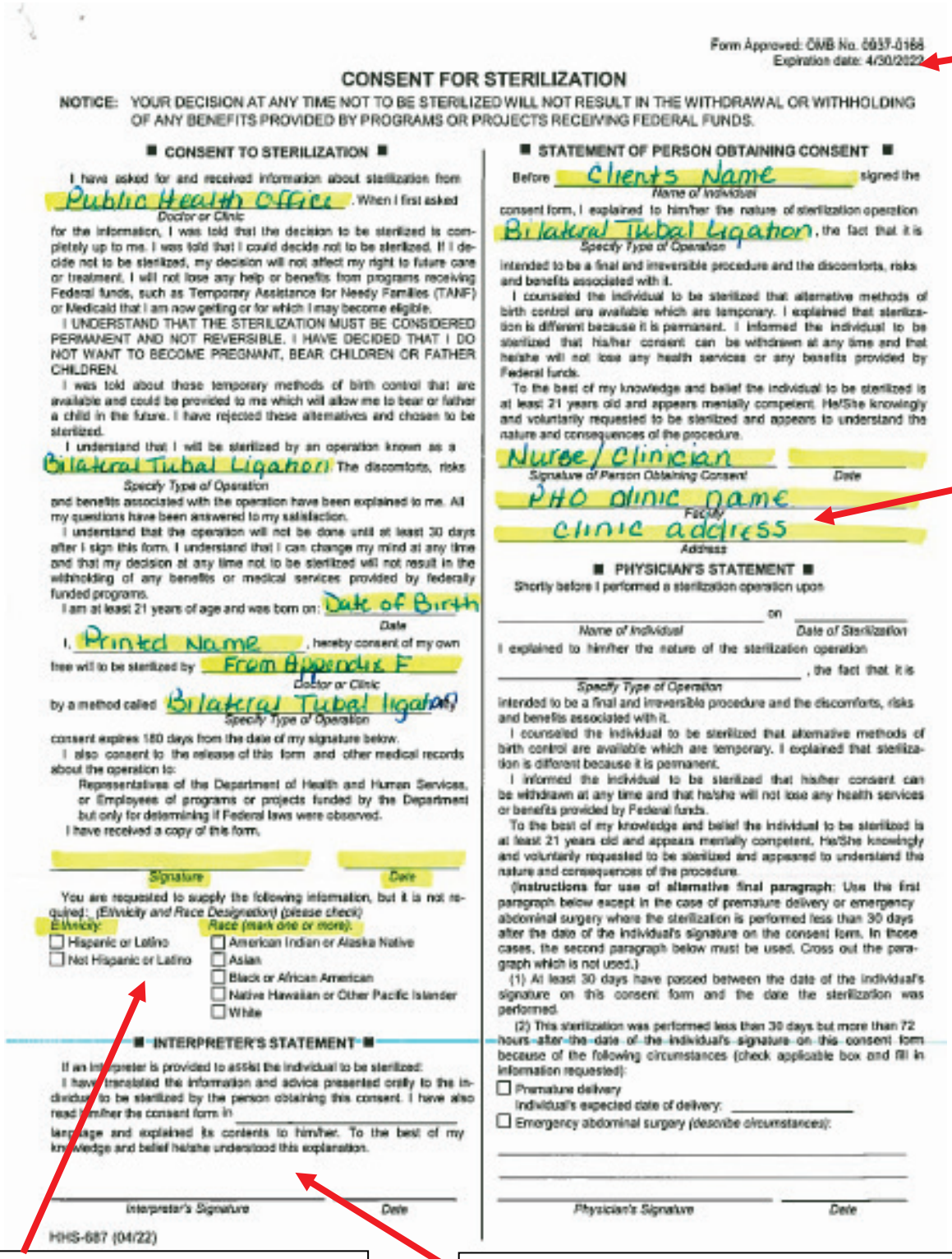
**Section 10**

All 3 questions should be "no" to qualify

Surgeon Signature

10/2022

# Consent For Sterilization Form



Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

## CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

### CONSENT TO STERILIZATION

I have asked for and received information about sterilization from Public Health Office (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a Bilateral Tubal Ligation (Specify Type of Operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: Date of Birth (Date)

I, Printed Name, hereby consent of my own free will to be sterilized by From Appendix F (Doctor or Clinic) by a method called Bilateral Tubal ligation (Specify Type of Operation).

This consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (Signature) _____ (Date)

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

### INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter's Signature) _____ (Date)

HHS-687 (04/22)

### STATEMENT OF PERSON OBTAINING CONSENT

Before Clients Name (Name of Individual) signed the consent form, I explained to him/her the nature of sterilization operation Bilateral Tubal Ligation (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Nurse / Clinician (Signature of Person Obtaining Consent) _____ (Date)

PHO clinic Name (Facility)

clinic address (Address)

### PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (Name of Individual) on _____ (Date of Sterilization)

I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery (describe circumstances):

_____

_____

_____ (Physician's Signature) _____ (Date)

Make sure form has not expired

Use mailing address of PHO

This section to be completed by Surgeon performing the procedure.

If client refuses to answer, please indicate so on form here for Federal reporting purposes.

If interpreter was used, write in language (e.g., Spanish), and signature of staff that provided interpretation.

If interpreter phone line used, document this information.