## 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	g from
	name of clinic or
before my operation was p	performed.
I talked to about a hy	/sterectomyshe/he/thev
discussed it with me and gave me a chance to ask qu	
before the operation.	
I have read all of this notice. I agree that it is a true d	lescription of what was explained to
me by of clinic/hosp	and that pital/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)  Physician	or assistant(s) of his or her choice.
I consent (or did consent) to any other medical treatment	ment that the doctor thinks is (was)
necessary to preserve my health.	
I also consent to the release of this form and other m representatives of the United States Department of H employees of programs or projects funded by that De determining if Federal laws were observed.	lealth and Human Services or
Recipient's Signature	Date: Month/Day/Year

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## 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.