Oregon Health Authority

Ages 15-20 Consent to Sterilization

Client Name	
Client sex ❑ Female ❑ Male	Medicaid ID Number

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.

Patient's Statement

I have asked for and received information about sterilization from_____ (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 AFDC 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 _____.

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 of medical services provided by Federally funded programs.

I am between 15-20 years of age and was born on _____ (month/day/year).

I, _____, hereby consent of my own free will to be sterilized by _____(doctor) by a method called _____.

My 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 (DH) and Oregon Health Authority (OHA) or Employees of programs or projects funded by the DH but only for determining if Federal laws were observed. I have received a copy of this form.

Signature _____

Date _____ (month/day/year).

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

- ❑ Black (not of Hispanic origin)
- ❑ White (not of Hispanic origin)
- ❑ Asian/Pacific Islander
- ❑ American Indian/ Alaska Native
- ❑ Hispanic

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 _____ (month/day/year).