# D.44 Sterilization Consent Form (Spanish)

**AVISO: SI EN CUALQUIER MOMENTO USTED DECIDE NO DEJARSE ESTERILIZAR, ESTA DECISION NO RESULTARA EN LA RETENCION NI EL RETIRO DE BENEFICIOS OFRECIDOS POR NINGUN PROGRAMA O PROYECTO QUE RECIBA FONDOS FEDERALES.**

**CLIENT MEDICAID/FAMILY PLANNING NUMBER**

/_/_/_/_/_/_/_/_/_/_/_/

**CONSENTIMENTO PARA LA ESTERILIZACION**

Yo, _______________ (nombre completo de la persona que se va a operar) con residencia en __________________________ (dirección), he solicitado y he recibo información sobre la Esterilización de _______________________________ (nombre del doctor o de la clínica) Cuando solicité la información, me dijeron desde un principo que yo mismo haría la decisión sobre esterilizarme o no. Si decido noesterilizarme, esta decisión no afectará mi derecho a atención y tratamiento en el futuro. Tampoco resultará en la pérdida de ayuda y beneficios de programas que reciben fondos federales, como, por ejemplo, T.A.N.F. y Medicaid, que recibo ahora o que pueda calificar para recibir después.

**COMPRENDO QUE LA ESTERELIZACION SE CONSIDERA PERMANENTE E IRREVERSIBLE. HE DECIDIDO QUE NO DESEO CONCEBIR, DAR A LUZ, NI ENGENDRAR HIJOS.**

Me describieron los métodos temporales de control de la natalidad que se pueden emplear y que me pueden ofrecer, que me permitirían en el futuro encargar o engendrar un hijo. He rechazado esas alternativas y he elegido ser esterilizado(a).

Comprendo que mi esterilización será por medio de una operación que se llama ________________________________.

Me han explicado las molestias y riesgos de la operación, lo mismo que los beneficios. Contestaron a mi satisfacción todas las preguntas que tuve. Comprendo que la operación no se hará hasta 30 días después de firmar yo este consentimiento. Contestaron que puedo cambiar de opinión cualquier momento y que mi decisión en cualquier momento de no esterilizarme no resultará en la retención de
ningunos beneficios o servicios de programas que reciben fondos federales. Tengo al menos 21 años de edad. Nací el (día)_____________ (mes)____________________ (año)___________.

Yo, ____________________, con esto consiento voluntariamente a la esterilización practicada por ---_________________ empleando el método que se llama ______________________.

Este consentimiento expira a los 180 días de la fecha de mi firma al final de este documento. También autorizo que se den copias de este consentimiento y de otros documentos médicos relativos a mi operación a:

Representantes del Departamento de Salud y Servicios Humanos, o Empleados de programas o proyectos que reciben fondos de ese Departamento, sólo para determinar si las leyes federales fueron observadas.

He recibido una copia de este consentimiento.

Firma:_____________________________________

Fecha: _________________ (hora y mes, día, año)

**AVISO:** Se le pide a usted que ofrezca la siguiente información,pero no es requisito.

**DESIGNACION ETNICA O DE RAZA** (por favor, marque uno)

Negro (no de origen Hispano)___________________________

Origen Hispano_____________________________________

Asiático o de las Islas del Pacífico________________________

Indio Americano o Indígena de Alaska___________________

Blanco (no de origen Hispano)__________________________

**INTERPRETER'S STATEMENT** (all blanks must be completed if an interpreter is used)

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 individual 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.

Signature of the interpreter:_______________Date:_________

**STATEMENT OF PERSON OBTAINING CONSENT**

Before,__________________(name of individual) signed this consent form, I explained to him/her the nature of the sterilization 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 appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent:

_________________________________________________

Date: ____________________(month, day, year)

Facility: ____________________________________________

Address:____________________________________________

**PHYSICIAN'S STATEMENT**

Shortly before I performed a sterilization operation upon ________________________(name of individual to be sterilized), on __________________________________ (time and date of sterilization operation), I explained to him/her the nature if the sterilization operation___________________ (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 paragraphs: Use the first paragraph below except in cases 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:
_________________________________________________

Signature of Physician: ___________________Date:_____

**FUNDING SOURCE (Office Use Only)**

Please circle one

**Title XIX** **Non-Title XIX**