SOUTH DAKOTA MEDICAID
ACKNOWLEDGEMENT OF INFORMATION
FOR HYSTERECTOMY

Instructions
A recipient must sign the statement below acknowledging receipt of infertility information prior to surgery unless the hysterectomy is performed under a life-threatening emergency situation in which prior acknowledgement was not possible. If the procedure is performed under a life-threatening emergency situation in which prior acknowledgement was not possible, the Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed the Interpreter statement must be completed.

Acknowledgement
I understand and fully acknowledge that the surgical procedure of hysterectomy renders me permanently sterile. I confirm that this information was communicated to me prior to the surgery or was communicated to me after the surgery due to a life-threatening emergency.

_____
Recipient's name (please print)

_____
Recipient Medicaid ID #

_____ _____
Recipient signature Date of signature

Interpreter Statement (if applicable)
I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____
Interpreter's Name

_____
Date of interpretation