Patient Identification
Name:________________________________
Medical Record Number: ________________
Birthdate: _____________________________

KAPIʻOLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN

VOLUNTARY STERILIZATION

You have the right and obligation to make decisions concerning your healthcare. Your physician/practitioner has the duty to provide you with the necessary information and advice; however you are responsible to participate in the decision-making process. Please feel free to ask any questions. Your signature on this form acknowledges your understanding of and agreement to the treatment recommended by your physician/practitioner after being informed of the risks, benefits and alternatives.

VOLUNTARY STERILIZATION
(Supplemental Form to Informed Consent)

__________ (initial) It is my intention that this operation be permanent. I also understand that my physician cannot and has not guaranteed this operation since there have been failures with all procedures.

__________ (initial) I realize that after such an operation, it is unlikely, but not impossible, that I shall ever conceive or bear children.

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS.

Acknowledgments: The available alternatives, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment have been explained to me. I understand what has been discussed with me as well as the contents of this form, and have been given the opportunity to ask questions and have received satisfactory answers.

______________________________________ ____________ ____________
Signature of Patient (or person authorized to sign for patient) Date Time

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Relationship of Person Authorized to Consent for Patient

______________________________________ ____________ ____________
Signature of Responsible Practitioner/Physician Date Time