SAN FRANCISCO HEALTH PLAN
Here for you

Policy and Procedure Template

Policy Name:	Personnel Training: Informed Consent and Human Sterilization Consent		
Effective Date:		Revision Date:	
Department(s)/Site(s):			
Document Owners:			
Approved By:			
Relevant Law/Standard:	California Department of Health Care Services under Title 22, California Code of Regulations, Section 53230. (Requires the review and certification of Primary Care Practitioner (PCP) sites.) Department of Health Care Services (DHCS) All Plan Letter 20-004, Facility Site Reviews.		

Policy:
Site personnel receive training and/or information on member rights that include informed consent and human sterilization consent.

Procedure:

1. Written Member Rights should be available at the office site. Staff should be able to locate the written Member Rights list and explain how to use the information.
2. Staff trainings regarding member rights may be part of office staff education documented in
    - Informal or formal in-services
    - New staff orientation
    - External training courses
3. Topics included in the training must include:
    a. Informed Consent for Human Sterilization

Patients shall be informed about any proposed treatment or procedure that includes medically significant risks, alternate courses of treatment or non- treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment. Documentation of this discussion and the signed consent shall be written and included in the member's medical record.

Note: patient rights incorporate the requirements of the Joint Commission on Accreditation of Healthcare Organizations, Title 22, California Code of Regulations, Section 70707 and Medicare Conditions of Participation.

Requirements include and are not limited to:

- Conducted by physician or physician designee
- Offered booklet published by the DHCS and copy of consent form must be given to the member.
- Provided answers to any question the member may have.
- Inform the member may withdraw or withhold consent to procedure at any time before the sterilization.
- Describe fully the available alternatives of family planning and birth control.
- Advise that the sterilization procedure is considered irreversible.
- Explain fully the description of discomforts and risks and benefits of the procedure.

Utilize the PM330 sterilization consent form. Forms may be ordered directly from the DHCS by placing a request to:

Department of Health Care Services Warehouse
1037 North Market Blvd, Suite 9
Sacramento, Ca 95834
Fax: 916-928-1326

Consent Form PM 330: Consent to Sterilization may be downloaded here:
https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf

An explanation of Consent Form PM 330 may be found here:
http://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_example.pdf

_____ _____
First Name Last Name – Title Date

_____ _____
First Name Last Name – Title Date

The material in this document is a knowledge-sharing tool provided by the FSR team to enhance compliance with Facility Site Review requirements. All content is for informational purposes and may be used and/or modified according to site-specific practices. Ensure appropriate review and approval by site management prior to adoption.

State of California – Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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.

■ CONSENT TO STERILIZATION ■

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 A.F.D.C. 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 _____ (Name of procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty 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 or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____. (Mo / Day / Yr)

I, _____ (Last) _____ (First) _____ (M. I.)

hereby consent of my own free will to be sterilized by _____ (Doctor's name) by a method called _____ (Name of procedure).

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 and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ Date: ____/____/____
Signature of individual to be sterilized Mo Day Yr

■ 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.

_____ Date: ____/____/____
Signature of Interpreter Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual to be sterilized) signed the consent form, I explained to him/her the nature of the sterilization operation _____ (Name of procedure), 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 anytime and that he/she will not lose any health services or any 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 consequences of the procedure.

_____ Date: ____/____/____
Signature of person obtaining consent Mo Day Yr

_____
Name of Facility where patient was counseled

_____
Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on ____/____/____ (Mo / Day / Yr) (Date of Sterilization), I explained to him/her the nature of the sterilization operation _____ (Name of procedure), the fact that it is intended to be 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 the case of premature delivery or emergency abdominal surgery when 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 below which is not used.**

(1) At least thirty 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 below and fill in information requested**.)

A Premature delivery date: ____/____/____ Individual's **expected date** of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B Emergency abdominal surgery; describe circumstances: _____

_____ Date: ____/____/____
Signature of Physician performing surgery Mo Day Yr