

APPLICATION CUM CONSENT FORM FOR STERILIZATION OPERATION

Name of Health Facility:

Beneficiary Hosp Registration Number: **Date:**...../...../20....

1. Name of the Acceptor: Shri/Smt.

.....

2. Name of Husband /Wife: Shri/Smt.

Address

..... **Contact No:**

3 Names of all living, unmarried dependent Children (Fa an chenpui mekte hming)

i).....Age.....

ii).....Age.....

iii).....Age.....

iv).....Age.....

4. Father’s Name of beneficiary: Shri......

Address:

5. Religion/Nationality:

6. Educational Qualifications:

7. Business/Occupation:

8. Operating Centre:

I, Smt/Shri, hereby give consent for my sterilization operation. I am married and my husband/wife is alive. My age is years and my husband’s/wife’s age is years. I have male and female living children. The age of my youngest living child is years.

I am aware that I have the option of deciding against the sterilization procedure at any time without sacrificing my rights to other reproductive health services.

Kei, Pi/Pu hian fanei thei lo tura insiam tur hian ka remtihna ka pe a. Nupui/Pasal nei lai ka ni a, kan Nu/Pa pawh a dam tha a. Kum mi ka ni a, Ka Nupui/Ka Pasal chu Kum mi a ni. Fapa Fanu dam kan nei a, a naupang ber chu Kum mi a ni.

Hei fanei thei tawh lo tura insiam hi ka duh chuan thulhin, indanna dang ka hmang zawk thei reng tih ka hria.

a. I have decided to undergo the sterilization/re-sterilization operation on my own without any outside pressure, inducement or force. I declare that I/my spouse has not been sterilized previously (may not be applicable in case of re-sterilization).

a. ***He insiamna hi keima duhthu ngei leh tu tihluhna mah ni lovin ka thlanga. Ka Nupui/Pasal hi fanei thei lo tura siam ala ni lo tih ka hre bawk. (Siam nawn ngai case ah chuan hei hi a tul kher lo***

b. I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent. I also know that there are still some chances of failure of the operation for which the operating doctor and the health facility / Health Department / State Government will not be held responsible by me or by my relatives or by any other person whomsoever.

b. ***Fa nei lo tura indanna chi dang ka hmang thei reng tih pawh ka hria a. He insiamna (Tubectomy) vang hian Fa a neih theih tawh loh tih pawh ka hre bawk. Amawherawhchu he Insiamna Operation hi Fail thei a nih thu leh Nau pai leh palh thei ani tih ka hria a, chutianga nau ka pai leh palh a nih pawhin min zaitu Doctor leh damdawiina thawkte leh Health Department emaw State Sawrkar emaw ah keiin emaw, ka chhungte emaw, midang tupawhin kan mawhpahin thubuai ah kan la lovang.***

c. I am aware that I am undergoing an operation that carries an element of risk

c. ***He Operation hian thil tha lo eng eng emawa thlen palh thei tih ka hria.***

d. The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to the criteria.

d. ***He insiamna atana thil tul hrang hrang te min hrilhfiah vek a. Heng thil tul hrang hrang te ngaihtuah hian, insiam thei ka ni tih ka chiang bawk.***

e. I agree to undergo the operation under any type of anaesthesia that the doctor/Health facility thinks suitable for me and to be given other medicines as considered appropriate by the Doctor/health facility concerned.

e. ***He insiamna atan hian anaesthesia (Hnimhlum/Kah hitna) engpawh Doctor te leh a thawktuten tul leh tha an hman ka remti a, damdawi tul leh tha an tih ang ang an hman ka remti bawk.***

f. If, after the sterilization operation, I experience a missed menstrual cycle, then I shall report within two weeks of the missed menstrual cycle to the Doctor/Health facility and may avail of the facility to get an MTP done free of cost.

f. ***He insiamna Operation hnua thi hul (missed period) thutah pawh, thi hul atanga chawlhkar hnih chhungin Doctor te hnenah hian a thlawna tih tlak turin ka in report bawk ang.***

g. In case of complications following sterilization operation, including failure, and the unlikely event of death following sterilization, I/my spouse and dependent unmarried children will accept the compensation as per the existing provisions of the Government of India “Family Planning Indemnity Scheme” as full and final settlement and will not be entitled to claim any compensation over and above the compensation offered under the “Family Planning Indemnity Scheme” from any court of law in this regard or any other compensation for upbringing of the child. (...)

g. **He ka insiam avanga harsatna ka tawh emaw, ka insiamna hi a lo hlawhchham palh emaw, ka insiam avanga thihna hial ka lo tawh palh a nih pawhin, kei emaw ka kawppui leh ka fate hian Government of India in ‘Family Planning Indemnity Scheme’ an siama Compensation (zangnadawmna) a pek theih bak aia tam he mi chungchangah emaw ka fa te enkawlnan, dan leh court kaltlang pawhin engmah ka beisei lo ang..**

h. I agree to come for follow-up visits to the hospital/institution/doctor/health facility as instructed, failing which I shall be responsible for the consequences, if any.

h. A tul ang leh nuin thurawn dan ang zela checkup tura Doctor leh thawktu te hnena lo kal ka remti a, Ka lo kal loh chuan engpawh thleng se ka mawh a ni ang.

i. I understand that vasectomy does not result in immediate sterilization. *I agree to come for semen analysis three months after the operation to confirm the success of the sterilization surgery (azoospermia), failing which I shall be responsible for the consequences, if any.

(Applicable in cases of Male Sterilization)*

i. Mipa insiam (vasectomy) hnu hian engemaw chen fa neih theih tho a ni tih ka hre thiam a. Insiamna result ti Chiang Turin “Semen Analysis” atan thla thum hnuah in-report ka tiam a, hei hi ka tih loh chuan engpawh thleng se ka mawh a ni ang. (Mipa insiam te tan)

I have read the above information.

The above information has been read out and explained to me in my own language, and it has been explained to me that this form has the authority of a legal document.

A chungah thu inziak khi ngun takin ka chhiar e.

A thute hi ka hriatthiam vek tura hrilhfiah ka ni bawh a, he lehkhabu hi “Legal Document” a ni tih pawh hrilhfiah ka ni.

Date:

Signature or Thumb Impression of the Acceptor

Name of acceptor:

Signature of Witness (Accepters side):

.....

Full Name:

Signature of witness:

Full Address:

(Only for those beneficiaries who cannot read and write)

Applicable to cases where the client cannot read and the above information is read out

Shri/Smt has read/have been fully explained about the contents of the Informed Consent Form in his/her local language.

Signature of Counselor:

Full Name:.....

Date: **Full Address:**

I certify that I have satisfied myself that -

a. Shri/Smt.....is within the eligible age-group and is medically fit for the sterilization operation.

b. I have explained all clauses to the client and that this form has the authority of a legal document.

c. I have filled the Medical record-cum-checklist and followed the standards for sterilization procedures laid down by the Government of India.

Signature of Operating Doctor

Signature of Medical Officer in-charge of the Facility

(Name of Operating Doctor)

(Name of Medical Officer in-charge of the Facility)

Date:

Date:

Seal

Seal

DENIAL OF STERILIZATION

I certify that Shri/Smt.....is not a suitable client for re-sterilization /sterilization for the following reasons:

1.
2. He/

She has been advised the following alternative methods of contraception.

1.
2.

Signature of the Counselor or
Doctor making the decision**

Date: **Name and full Address:**

(** Counselor can be any health personnel including doctor)

MEDICAL RECORD AND CHECKLIST FOR FEMALE/MALE STERILIZATION

(TO BE FILLED BEFORE COMMENCING THE OPERATION)

NAME OF HEALTH FACILITY:.....

BENEFICIARY REGISTRATION NUMBER..... DATE:.....

A. ELIGIBILITY:

Client is within eligible age	Yes.....No.....
Client is ever married	Yes.....No.....
Client has at least one child more than one year old	Yes.....No.....
Lab investigations (Hb, urine) undertaken are within normal limits	Yes.....No.....
Medical status as per clinical observation is within normal limits	Yes.....No.....
Mental status as per clinical observation is normal	Yes.....No.....
Local examination done is normal	Yes.....No.....
Informed consent given by the client	Yes.....No.....
Explained to the client that consent form has authority as legal document	Yes.....No.....
Abdominal / pelvic examination has been done in the female and is WNL	Yes.....No.....
Infection prevention practices as per laid down standards	Yes.....No.....

B. MEDICAL HISTORY

	Recent medical Illness	Yes..... No.....
	Previous Surgery	Yes..... No.....
	Allergies to medication	Yes..... No.....
	Bleeding Disorder	Yes..... No.....
	Anemia	Yes..... No.....
	Diabetes	Yes..... No.....
	Jaundice or liver disorder	Yes..... No.....
	RTI/STI/PID	Yes..... No.....
	Convulsive disorder	Yes..... No.....
	Tuberculosis	Yes..... No.....
	Malaria	Yes..... No.....
	Asthma	Yes..... No.....
	Heart Disease	Yes..... No.....
	Hypertension	Yes..... No.....
	Mental Illness	Yes..... No.....
	Sexual Problems	Yes..... No.....
	Prostatitis	Yes..... No.....
	Epididymitis	Yes..... No.....

	H/O Blood Transfusion	Yes..... No.....
	Gynecological problems	Yes..... No.....
	Currently on medication (if yes specify)	Yes..... No.....
	LMP	Date:

Comments.....
.....
.....

C. PHYSICAL EXAMINATION

BP.....Pulse.....Temperature.....

	Lungs	Normal..... Abnormal.....
	Heart	Normal..... Abnormal.....
	Abdomen	Normal..... Abnormal.....

D. LOCAL EXAMINATION

1. MALE STERILIZATION

	Skin of Scrotum	Normal..... Abnormal.....
	Testis	Normal..... Abnormal.....
	Epididymis	Normal..... Abnormal.....
	Hydrocele	Yes..... No.....
	Varicocele	Yes..... No.....
	Hernia	Yes..... No.....
	Vas Deferens	Normal..... Abnormal.....
	Both Vas Palpable	Yes..... No.....

2. FEMALE STERILIZATION

	External Genitalia	Normal..... Abnormal.....
	PV Examination	Normal..... Abnormal.....
	PS Examination	Normal..... Abnormal.....
	Uterus Position	A/V..... R/V..... Mid position..... Not determined.....
	Uterus size	Normal..... Abnormal.....
	Uterus Mobility	Yes..... No.....
	Cervical Erosion	Yes..... No.....
	Adnexa	Normal..... Abnormal.....

E. LABORATORY INVESTIGATION

	Hemoglobin levelGms%	
	Urine: Albumin	Yes..... No.....	
	Urine- Sugar	Present..... Absent.....	
	Urine test for Pregnancy	Positive.....Negative.....	
	Any Other (specify)	

Name:

Signature of examining doctor:

Date:

HOSPITAL SEAL