**APPLICATION CUM CONSENT FORM FOR STERILIZATION OPERATION**

**Name of Health Facility: …………………………………………………………………….**

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

1. **Name of the Accepter:** 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).

1. ***He insiamna hi keima duhthu ngei leh tu tihluihna 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***
2. 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 mawhpuhin thubuai ah kan la lovang.***

1. I am aware that I am undergoing an operation that carries an element of risk
2. ***He Operation hian thil tha lo eng eng emawa thlen palh thei tih ka hria.***
3. 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.
4. ***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.***
5. 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.
6. ***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.***
7. 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.
8. ***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.***
9. 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. ( …)
10. **He ka insiam avanga harsatna ka tawk emaw, ka insiamna hi a lo hlawhchham palh emaw, ka insiam avanga thihna hial ka lo tawk 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..**
11. 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.
12. ***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.***
13. 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)*

1. ***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 chunga thu inziak khi ngun takin ka chhiar e.**

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

**Date: ……………… Signature or Thumb Impression of the**

 **Acceptor**

**Name of accepter: …………………………………**

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:……………..**

1. **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………… |

1. **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………… |

1. **LOCAL EXAMINATION**
2. 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………………. |

1. 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………… |

1. **LABORATORY INVESTIGATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Hemoglobin level | …………………………………….Gms% |  |
|  | 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**