

INDIVIDUAL STERILIZATION REPORT

Bureau of Maternal, Infant and Reproductive Health
 NYC Department of Health and Mental Hygiene

Reporter/Physician Information

1 Date Report Completed Month Day Year
 / /

2 Name of Person Completing Report

Last Name

First Name

Unknown

3 Name of Facility Where Procedure was Performed

4 Address of Facility Where Procedure was Performed

5 Phone Number of Facility Where Procedure was Performed

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6 Name of Physician who Performed Procedure

Last Name

First Name

Patient Information

7 Date of Birth

Month Day Year
 / /

9 Borough of Residence

Not Applicable

8 Country of Birth

10 Zip Code of Residence

11 Sex

- Male
 Female

12 Race/Ethnicity

- Black non-Hispanic Asian Unknown
 White non-Hispanic Hispanic Other (specify) _____

13 Medical Record Number

Procedure Information

14 Date Consent Form signed

Month Day Year
 / /

Unknown

15 Consent Form signed at a different facility? Yes No

16 Consent Form in patient chart? Yes No

17 Name of person who obtained consent: _____

Unknown

18 Is English the patient's primary language?

- Yes No Unknown

a. If No, language used during counseling: _____

b. Did Interpreter sign the Consent Form?

- Yes No Unknown

19 Was a contraception method prescribed during the waiting period before the sterilization procedure?

- Yes No Unknown Not Applicable

20 Date Reaffirmation of consent signed

Month Day Year
 / /

21 Date Sterilization procedure performed

Month Day Year
 / /

22 Was procedure performed less than 30 days after consent was signed? Yes No

a. If Yes, was this due to: Premature/Early Delivery

Emergency Surgery

Other (specify) _____

23 Type of Procedure:

Laparotomy

Mini-laparotomy

Laparoscopy

Colpotomy

Trans-cervical tubal occlusion

Vasectomy

Other (specify) _____

24 Procedure Associated With:

Vaginal Delivery

Cesarean Delivery

Abortion (spontaneous or elective)

Abdominal Surgery

Other (specify) _____

Not Applicable

Individual Sterilization Report Instructions

- Complete the form using a pen with black ink
- Print all text fields legibly
- DO NOT put the patient's name anywhere on the form
- Complete this form only for procedures which require an LDSS-3134 Sterilization Consent Form

Send the completed original form to the New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health, 2 Lafayette Street, 18TH Floor, CN 34A, New York, NY 10007

1. Enter the date that the report form was completed
2. Print the name of the person who is completing the report
3. Print the name of the facility where the sterilization procedure was performed
4. Print the address of the facility where the sterilization procedure was performed
5. Enter the phone number of the facility where the procedure was performed
6. Print the name of the physician who performed the procedure
7. Print the patient's date of birth
8. Print the patient's country of birth (DO NOT enter the patient's current place of residence in this field)
9. Print the patient's borough of residence; if the patient does not live in one of the five boroughs, check the box labeled "not applicable"
10. Enter the zip code of the patient's place of residence
11. Check the box indicating the patient's sex
12. Check the box indicating the patient's race/ethnicity
13. Enter the patient's medical chart number
14. Enter the date that the initial consent form was signed
15. Check the box indicating whether the patient's original consent form was signed at a facility other than the site where procedure was performed
16. Check the box indicating whether the patient's original consent form is in the medical chart
17. Print the name of the person who originally obtained consent from the patient (this is located in the upper right of the LDSS-3134 Sterilization Consent Form)
18. Check the box indicating whether English is the patient's primary language; if not, print the language that was spoken during counseling, and check the box that documents whether an interpreter signed the consent form
19. Check the box indicating whether a contraception method was prescribed during the waiting period prior to sterilization
20. Enter the date that the patient signed the reaffirmation statement (this is found at the bottom of the LDSS-3134 consent form)
21. Enter the date that the sterilization procedure was performed
22. Check the box indicating whether the surgery occurred less than thirty days after consent was signed; if the box labeled "Yes" has been checked, check one box documenting the specific medical indication, or print an alternative explanation in the space next to option "Other"
23. Check the box indicating the type of sterilization procedure performed. Please be aware of the following:
 - Procedures that are done at the same time as a cesarean delivery should have laparotomy listed as the procedure type
 - Procedures done during a hospital stay for a vaginal delivery should have the procedure type listed as mini-laparotomy
 - Procedures done using hysteroscopic methods (e.g. Essure) should have trans-cervical tubal occlusion listed as the procedure type
24. Check the box for procedures that occurred in conjunction with or directly preceded the sterilization