Annexure - 2

Application for Sterilisation Operation and Consent Form

1. Name : Shri/Smt _____

2. Husband's name and address _____

3. Father's name and address _____

4. Operation Center _____

Dear Sir/ Madam,

Kindly make arrangements for my sterilization operation. My age is _____ Years and my husband's/wife's age is _____years.

I am married and my husband/wife is alive. We had ____ male and ____female living children. The age of my youngest living is _____yrs. I have decided to undergo sterilization operation independently and on my own without any outside pressure, inducement or force. I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent and that after the operation know that for all practical purposes this operation is permanent and that there are still some chances of failure of the operation for which the hospital/institution and operating doctor will not be held responsible by me or my relative or any other person whomsoever. My husband/wife has not been sterilized proviously. I am undergoing operation, which carries an element of risk. I have been explained the eligibility criteria for the operation and I affirm that I am eligible to undergo operation according to criteria. I agree to undergo the operation under any type of anaesthesia which the doctor thinks suitable for me. After sterilization operation if I get pregnant, then I shall report within four weeks to the doctor/hospital and will get abortion done free of cost. Under such circumstances, the State Government will pay a compensation of Rs.5000/- to me which will be acceptable to me. I know that if I am unable to get the pregnancy aborted within four weeks of pregnancy, then I will not be entitled to claim any compensation from any court of law in this regard. I agree to come for follow-up to the center / doctor as instructed, failing which I shall be responsible for the consequences, if any

I have read the above-mentioned facts/information* in my own language.

Religion : _____

Age : _____

Buisness/Ocupation : _____

Signature of the acceptor / applicant

Signature of the witness

Full Name _____

Full address _____

_____

*(Only for those beneficiaries who cannot read and write)

Shri/Smt _____ have been explained other methods of contraception available and the failures associated with other methods have been explained fully.

**Signature of Counsellor

Full Name _____

Full address _____

_____

I know very well Shri / Smt _____ and the information given by me/her is correct. His/her name has been registered with health centre/City centre at Sal. No._____

Signature of Promotor _____

Full Name _____

Full address _____

_____

CERTIFICATE OF MEDICAL OFFICER

I certify that I have satisfied myself that Shri / Smt _____ is within the eligible age-group and is mentally and medically fit for a sterilization operation. There is no evidence that he/she has undergone a sterilization operation previously. I have explained all clauses to the clauses to the client and that this form has the authority of a legal document.

*Signature of operating doctor

Signature of medical officer

Name and address

Name and address

DENIAL OF STERILIZATION

I certify that Shri / Smt _____ is not suitable client for resterilization/sterilization for the following reasons.

1.

2.

He / she has been provided the following alternative methods of contraception.

Signature of counselor** or Doctor making decision

(Name and Address)

**counsellor can be any health personnel including doctor.

For Official use only

d) To be filled by examining doctor

Note : If the surgeon is himself health examiner, the certificate may be Given by him.

Age of the client according to appearance _____

Urine analysis for sugar_____

Blood Pressure _____

Whether client has gone sterilization earlier or not _____

As per examination by the doctor, the client is mentally and medically fit for sterilization operation.

I have confirmed from the client regarding his/her marital status and number of living children. I have explained pros adn cons of the sterilization operation to the client and he himself is mentally ready for the operation.

Signature of the client_____

Signature of the Surgeon

(Name in capital letter)

Present Place of Posting

E) CERTIFICATE OF THE SURGEON

I have performed sterilization operation. During the operation there was no visible signs of earlier sterilization and as per appearance he/she was within the age limit for sterilization. If it is female sterilizaiton, the type of operation performed -

abdominal / vaginal / Laparoscopic / minilap
General / Local anesthesia used.

Signature of the Surgeon

(Name in capital letter)
_____

Present Place Posting_____

Economic, Social and Demographic details of the client under going sterilizaiton operation

Monthly report of the District Family Welfare Bureau should be accompanied by the following profroma :

1	Name of client	
2	Name of head of the Family	Shri
3	Name of Father / Husband	Shri
4	Mohalla _____ House No. _____	
5	P.H.C./ Urban Center	
6	Ward	
7	Religion	
8	Caste	General / SC / ST / NT / VJNT / OBC Class_____
9	Whether married	Yes / No
10	Age of Applicant (complete years)	
11	Age Husband / Wife (complete years)	
12	No. of alive Children	

		a) Sons Age Husband	b) Daughters Months Wife
13	Age at marriage		
14	Educational qualification	Husband -	illiterate / Literate / Primary /Junior High School / High School / Graduate & above
		Wife -	illiterate / Literate / Primary /Junior High School / High School / Graduate & above
15	Difference from the last Termination of Pregnancy	_____years _____and_____	
		Delivery or abortion	

Payment Particulars : -

Amount given to applicant Rupees _____ Paise_____

For _____Sterilization

Date : Signature of applicant

Name

Follow up

Person concerned with the service fo the applicant Name _____

_____ Post _____

Place of Appointment_____

1. Promotor _____
2. Health Worker _____
3. Medical Officer, P.H.C. _____
4. Surgeon-_____

If tubectomy methods adopted.

Abdominal / Vaginal / Laparoscopic / Laprotomy

Type of anaesthesia : General / local / Spinal

Full Name of the person going to give follow up _____

Present Address _____

_____

Other Information

1) Whether any contraceptive method has been Adopted earlier : Yes / No
   If Yes
   (1) Name of the Method _____
   (2) Period of the Method _____
2) Whether Promotor of applicant is regional worker of family welfare programme Yes / No
   If Yes , whether applicant is inhabitant of the jurisdiction of that Worker Yes / No
3) Reason for the application of sterilisation : Limited family / diseasers / financial or other

I certify that above mentioned particular is correct.

Place _____

Signature _____

Full name

Present address