

KENTUCKY TITLE X STERILIZATION RECORD

For monitoring and auditing sterilizations subject to Federal Regulation 42 CFR 50.201

Reporting Period (From and To) _____ Agency name _____

UNIQUE PATIENT IDENTIFICATION (Do not use Names or Social Security Numbers)	RACE	DATE OF BIRTH	DATE CONSENT SIGNED BY THE PATIENT	DATE OF THE PROCEDURE	TYPE OF PROCEDURE	CIRCUMSTANCE	Federal Consent Form (HHS-687) is completed in entirety with no blanks.
					<input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Normal <input type="checkbox"/> Emergency Abdominal <input type="checkbox"/> Premature Delivery	YES OR NO
					<input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Normal <input type="checkbox"/> Emergency Abdominal <input type="checkbox"/> Premature Delivery	YES OR NO
					<input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Normal <input type="checkbox"/> Emergency Abdominal <input type="checkbox"/> Premature Delivery	YES OR NO
					<input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Normal <input type="checkbox"/> Emergency Abdominal <input type="checkbox"/> Premature Delivery	YES OR NO

Total number of hysterectomy or hysterectomies arranged for or performed _____

To the best of my knowledge the data reported above accurately represents the sterilization activities during the time specified.

NAME _____ **EMAIL** _____ **DATE** _____

Submit to: FamilyPlanning@ky.gov or upload with Quarterly Report