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Patient Medical Record (write in or apply sticker)

Name: _____

Medical Record No. _____

DOB: _____

Admitting MD: _____

Physician's Surgical Procedure Disclosure and Patient Consent: Vas - Vasectomy

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure so that you may decide whether or not to undergo the procedure after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it to you. You may have additional consent discussions regarding: anesthesia, the administration of blood or blood products, certain medications, or additional persons involved in the procedure you are consenting to.

REASON FOR PROCEDURE: I (we) voluntarily request my physician,_____, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition: **Desired sterility (inability to get a woman pregnant).**

PROCEDURE(S): I (we) understand that the following surgical procedure(s) is planned for me on or about (month)_____(day) _____ (year) _____. I voluntarily consent to and authorize this (these) procedure(s): **Vas - Vasectomy**

Procedure Description: This procedure involves removing small sections of the tubes that carry sperm from the testicles to the penis.

Your doctor will examine the scrotum. Your doctor will locate the tube (vas deferens) that carries the sperm from the testicles to the penis. A local anesthetic (numbing medication) is injected through the skin into the area around the tube. A small opening is made into the scrotum. The tube is grasped and a small piece of the tube is cut and removed. The open ends of the tube are closed. This is usually done with clips, sutures, and or cautery (burning or searing). This will be repeated to the tube on the other side using the same opening or another opening. These skin openings may be stitched closed or left open to heal on their own.

Some time after the procedure, you will provide at least one semen sample to your doctor. This is to make sure the procedure worked. You will not be considered sterile until the sample has been examined.

Proposed Benefit(s): This procedure will prevent you from getting a woman pregnant.

Site or location of the operation/procedure: See description of treatment/procedure.

MATERIAL RISKS: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and/or diagnostic procedure(s) planned for me, including:

- Blood in ejaculate (fluid from penis during orgasm). This may last for a period of time after procedure.
- Change in lifestyle with psychological stresses, including poor sexual performance.
- Pain, numbness, swelling, weakness or scarring where tissue is cut.
- Reversing this procedure may be difficult or impossible.
- Swelling of the penis and/or scrotum.
- Abnormal collection of blood in area. You may need drainage.
- Epididymitis. This is inflammation of the epididymis (a curved tube on top of the testicle that holds sperm).
- Infection of the wound.
- Long-term pain.
- Loss of testicle or testicle function. This may affect the ability to conceive children.
- No guarantee of infertility.
- Pain or discomfort during sex.
- Reaction to local anesthesia or other medicines given during or after the procedure.
- Granuloma. This is a lump of tissue that doesn't go away.
- Reopening of the tubes that carry sperm from the testicles to the penis. This means you may be able to get a woman pregnant.
- Damage to the blood vessels and other structures in the spermatic cord. This may lead to shrinkage or loss of the testicle.
- Complications from anesthesia. These may include irregular heartbeat, pneumonia, collapse of part or all of the lung, stroke, and/or heart attack.
- Accidental injection of the local anesthesia into a blood vessel. This may cause seizures or cardiac arrest. It may affect your brain temporarily or permanently. This may disturb heart and lung function.

Additional material risks of surgical, medical and/or diagnostic procedure(s) include: death, cardiac arrest, brain damage, disfiguring scar, paralysis or partial paralysis, loss or loss of function a limb or organ, blood clots in veins or lungs, severe loss of blood, allergic reaction, and infection.

ALTERNATIVES TO PROCEDURE: The following practical alternatives to this procedure, including the risks and benefits of those alternatives, have been discussed with me:

- Abstinence.
- Various forms of female birth control.
- Using condoms during sex.

- You may choose not to have this procedure.

LIKELY OUTCOME IF NO TREATMENT: I have been informed of the likely outcome if no treatment is provided, as follows: If you choose not to have this procedure, you will still be able to get a woman pregnant.

TREATMENT LIMITATIONS: I impose no specific limitations or prohibitions regarding treatment other than those that follow:

_____
_____
_____

DISPOSAL OF TISSUE: I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to accustomed practice.

BLOOD PRODUCTS: I (we) understand that if blood products are required, their use may improve my overall condition or save my life. I (we) understand that certain complications may result from the use of blood products. The more common risks include (but are not limited to) infection/irritation where the needle is placed, fever, chills, and skin rashes. Other rare but more serious complications may occur such as allergic reactions, shock, or death. I also know there is a very small risk of infection, including the risk of hepatitis {<1 in 200,000) and/or HIV/AIDS {<1 in 2 million).

[ ] I (we), **consent** to the use/administration/transfusion of blood products as deemed necessary.

[ ] I (we), **do not consent** to the use/administration/transfusion of blood products as deemed necessary.

CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS: I (we) understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

OUTCOME: I (we) understand that the practice of medicine is not an exact science, and that no warranty or guarantee has been made to me as to result or cure.

CONSENT TO TRAINING PARTICIPATION: My physician or this facility may have an educational role in the training of paramedical personnel.

Admittance of students and/or technical representatives

[ ] I (we) consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

[ ] I (we) do not consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

Admittance of students and/or technical representatives

[ ] I (we) consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.
[ ] I (we) do not consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

PHOTOGRAPHY: I (we) agree that still or video photography, audio recordings, or medical data may be taken during these treatments/procedures. These may be placed in my permanent medical record. I (we) agree that these images, recordings, or data may be used for education, training, or performance improvement programs as long as no information that could identify me is used.

MEDICAL DEVICES: I (we) accept that during the treatments/procedures, the doctor or dentist may need to place a medical device in my body. If a medical device is implanted in my body, personal information (such as my name, social security number, and medical information) will be given to the maker of the device for quality control purposes.

CONSENT:

I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the procedure described above.

I (we) certify that this form has been fully explained to me (us), and that I (we) have read it, or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

_____ _____ _____

Signature of patient or person authorized to give consent | (Relationship to patient) | Date

_____

Printed name of patient or person authorized to give consent

_____ _____

Signature of Witness (Include Position I Title) | Date

_____

Printed Name of Witness

To Be Completed By Physician After Patient Consent Completed:

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me to the patient or his or her legal representative before the patient or his/her legal representative consented.

_____ _____

Signature of Treating Physician | Date