

**Amery Wirtshafter, M.D.**

**David Robbins, M.D.**

**CONSENT FOR BILATERAL VASECTOMY**

Page I

I hereby authorize Amery Wirtshafter, M.D. and/or David Robbins, M.D. and any assistants as may be selected by said physician to treat the following condition(s):

**FERTILE MALE DESIRING STERILIZATION**

The procedure planned for the treatment of my condition(s) have been explained to me by my physician and are listed below:

**REMOVAL OF A SMALL SECTION OF VAS FROM BOTH SIDES (BILATERAL VASECTOMY)**

Possible risks associated with this procedure are:

- INFLAMMATION OR INFECTION OF TESTICLE(S) OR EPIDIDYMISS
- POSSIBLE RE-JOINING OF VAS ENDS RESULTING IN FERTILITY & PREGNANCY
- CHRONIC TESTICULAR DISCOMFORT OR SPERM GRANULOMA
- UNRECOGNIZED LONG-TERM EFFECTS OF VASECTOMY
- LONG-TERM EFFECTS OF VASECTOMY ARE STILL UNCERTAIN AND MAY BE ASSOCIATED WITH INCREASE RISK OF PROSTATE CANCER
- ALTERNATIVE THERAPY: OTHER FORMS OF CONTRACEPTION, MALE OR FEMALE

Our state laws guarantee that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

The information that follows is the text from the standardized Surgical Consent form. It is used for the most minor of procedures and the most complicated serious ones. It is not meant to frighten you but rather to inform you that ALL procedures carry some risks. Many operations, for instance, have only the remotest chance of needing blood transfusions, but

yet blood transfusions are mentioned. This form hopefully will allow you to better understand your upcoming operation. If you do not understand something, please ASK.

I recognize that during the course of the operation, post-operative care, medical treatment, anesthesia or other procedures, that unforeseen conditions may necessitate additional or different procedures than those set forth. I therefore authorize my above physician, and their assistants or designees, to perform such surgical or other procedures as are in the exercise of their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

I realize that all procedures have basic risks and potential complications. I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I realized that in those cases where an incision is needed, that infection, incisional pain, or hernia formation (weakness or bulging) can occur, and may require further treatments or procedures.

I realize that the list of risks and complications on this form may not include all possible or known risks or the intended surgery but is a list of the more common or severe ones. I realize that new risks that are not mentioned in this consent form may exist or may be found in the future.

I acknowledge that no warranty or guarantee has been made to me as to the results of my procedure or cure of my condition.

I consent to the administration of anesthesia by my attending physician, by an Anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks and potential complications and possible damage to vital organs such as the brain, heart, lung, liver and kidney, and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

I consent to the use of transfusions of blood and blood products as may be deemed necessary by my physician in accordance with accustomed practice.

I understand that any aspect of this consent form that I do not understand can be explained to me in further detail by asking my physician(s) or their associates.

I certify that my physician has informed me that the nature and character or the proposed treatment, or the anticipated results of the proposed treatment, or the possible alternative forms of treatment; and the recognized serious possible risk, complications, and anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non treatment.

I certify that I have read this three page consent and all my questions have been answered. I certify that I have not taken any aspirin or any blood thinners within two weeks of this procedure.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT NAME (PRINTED)

\_\_\_\_\_  
WITNESS

The medical procedure or surgery stated on this form (page I), including the possible risks, complications, alternative treatments (including non treatment) and anticipated results, were explained by me to the patient or his representative before the patient or his representatives consented.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE