



INFORMED CONSENT FOR PROCEDURE/OPERATION

FULL NAME OF PATIENT: _____

I.D. NUMBER: _____

PERSON OBTAINING CONSENT: _____

I have explained the nature, risks and possible consequences of the surgical procedure to the undersigned patient or person legally competent to give consent.

Signature: _____ Date: _____

PROPOSED PROCEDURE: CIRCUMCISION

THIS IS THE SURGICAL REMOVAL OF THE FORESKIN

INTENDED BENEFITS: TO TREAT FORESKIN ABNORMALITY / RELIGIOUS REASONS

SERIOUS OR FREQUENTLY OCCURRING RISKS: Including any extra procedures which may become necessary during the procedure. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

OCCASIONAL

Bleeding of the wound occasionally needing a further procedure.
Rarely, infection of incision requiring further treatment.
Permanent altered or reduced sensation of penis.
Persistence of absorbable stitches after 3-4 weeks, requiring removal

RARE

Scar tenderness, rarely long term.
You may not be completely cosmetically satisfied.
Occasional need for removal of excess skin at a later date.
Permission for biopsy of abnormal area on glans if malignancy a concern.

ALTERNATIVE TREATMENT Drugs to relieve inflammation, leave uncircumcised

NAME OF HEALTH PROFESSIONAL: _____

SIGNATURE: _____

STATEMENT OF PATIENT:

Please read this form carefully, particularly the previous page, which describes the benefits and risks of the proposed treatment.

I agree:

- To the procedure or course of treatment described on this form ☐
- To a blood transfusion if necessary ☐

I understand:

- That I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this.
- That any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or prevent serious harm to my health.

I have been told:

- About additional procedures which may become necessary during my treatment.

NAME OF PATIENT: _____

SIGNATURE: _____

DATE: _____