



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: PENILE STRAIGHTENING (NESBITTS)

THIS IS A PROCEDURE TO CORRECT PENILE CURVATURE

INTENDED BENEFITS: TO CORRECT THE CURVE IN YOUR PENIS

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.

COMMON

There is some shortening of penis.
Possible dissatisfaction with cosmetic or functional result.
Temporary swelling and bruising of penis and scrotum.

OCCASIONAL

Circumcision is sometimes required as part of procedure.
No guarantee of total correction of bending.
Recurrence of curve at later time.
Bleeding or infection requiring further treatment.

RARE

Impotence or difficulty maintaining erections can occur afterwards.
Nerve injury with temporary or permanent numbness of penis.

ALTERNATIVE THERAPY

Observation, drugs and other surgical approaches.

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: _____