



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: REVERSAL OF VASECTOMY

REJOINING OF THE PREVIOUSLY SEPARATED TUBES WITH TINY MICROSTITCHES

INTENDED BENEFITS: FERTILITY TREATMENT

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

Small amount of scrotal bruising.
No guarantee that sperm will return to semen.
Sperm may return but pregnancy not always achieved.
If storing sperm, check that the appropriate forms have been signed

OCCASIONAL

Bleeding, requiring further surgery.

RARE

Rarely, inflammation or infection of testes or epididymis requiring antibiotics.
Chronic testicular pain (5%) or sperm granuloma.

ALTERNATIVE TREATMENT Observation, urethral dilation, open (non-telescopic) repair of stricture.

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: PLEASE TICK

- 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: _____