THIS FORM IS TO BE SIGNED AT YOUR OFFICE VISIT

AUTHORIZATION FOR AND CONSENT TO SPECIAL DIAGNOSTIC/THERAPEUTIC PROCEDURE

I, _____ Give Dr. _____
permission to perform a **BILATERAL VASECTOMY.**

I have been informed that this procedure is intended to produce sterility even though the results cannot be guaranteed. I also understand that it is my responsibility to submit a post vasectomy sperm specimen for analysis three months after my vasectomy. I understand that I must utilize another form of birth control until this specimen is received and documented as negative. **Initials:** _____

Any tissue removed in the procedure will be disposed of at the discretion of the pathologist.

I am also aware that if the operation proves successful, the results are expected to be permanent. I have been told the remote possibility that nature may cause the passageways to re-open, thereby defeating the purpose of the operation. Also, I have been informed of the possible risks of the procedure such as: infection, excessive bleeding and chronic pain.

I have received the **VASECTOMY INFORMATION BOOKLET**, read it, and understand what my obligations are regarding the operation and post-operative follow up. I am aware that premature sexual intercourse without using some form of **BIRTH CONTROL** measures may result in an unintended pregnancy. I am also aware of the need to follow these instructions until my physician indicates the probability that the procedure has been a success.

My signature below constitutes my acknowledgment that I have read and agreed to the foregoing, that the operation has been adequately explained to me by my physician and that I have all the information that I desire and that I authorize and consent to the performance of the procedure.

_____ _____
Witness Patient's Signature

_____ AM
Date Time PM

****

RESPONSIBLE PARTY: _____

NURSING ASSESSMENT **Pre-Op. Med:** _____ **Time:** _____

Blood Thinner/Plavix, Aspirin, Coumadin, Vitamin E stopped on Date: _____

Pre-Procedure:BP _____ Post-Procedure: BP _____
T _____ P _____
P _____
R _____ Position: _____

Date: _____
Bilateral Vasectomy performed by Dr. _____
Patient tolerated procedure _____
Bleeding _____
Pre Procedure - Betadine solution to scrotal area _____
Post Procedure - Betadine ointment and bandaid(s) to operative site(s) _____
Discharge instructions reviewed with patient as outlined in pamphlet given to patient. _____

_____ RN/LPN/MA

SUBURBAN UROLOGIC ASSOCIATES

CANCELLATION POLICY FOR ELECTIVE PROCEDURES

You are scheduled for _____
on_____. If you decide not to proceed, you are **required to notify our office 7 days prior to the date of your procedure.**

If you do not notify our office by _____of your cancellation, you will be charged a **$100 Cancellation /No Show Fee**.
Any questions regarding this policy should be directed to our billing office at 412-374-8009.

I understand the cancellation policy regarding my elective procedure. I understand that I will be responsible for the $100 fee for not following this policy, should I desire to cancel or reschedule my procedure.

_____ _____

Patient Signature Date

_____

Print Name