

## CONSENT FOR SURGERY

1. I \_\_\_\_\_ hereby give my consent to John S. Gatewood, MD to perform a bilateral vasovasostomy. I understand that the procedure will involve a reconnection of the vas deferens under I.V. sedation and local anesthesia injected into the scrotum and its contents. I have made my decision voluntarily and freely. I also authorize Dr. Gatewood to perform, if he feels necessary, a vasoepididymostomy (or a connection of the vas deferens with the epididymal tubule). This will be done only in the event of a suspected blowout of the epididymus, or microscopic examination of the fluid from the testicular end of the vas implies epididymal obstruction. I further consent to the performance of operations, procedures, and treatment in addition to or different from that named above if, during the course of the operation, the above-named physician considers such addition or change necessary, appropriate, or advisable.
2. I have conferred with the above-named physician about the nature and purpose of the operation and I appreciate that there are certain risks associated with this procedure including pregnancy not guaranteed, mental anguish, and I freely assume these risks. I also understand that there are possible benefits associated with this procedure; pregnancy, sperm in the semen. I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding this procedure in producing a pregnancy or sperm in semen. I further understand that postoperative pain in scrotum or testicles, infection or bleeding in the scrotum or testicles, testicular atrophy or loss of circulation of blood to the testicle requiring removal of the testicle can result from this procedure.
3. I understand that there is the possibility that due to technical reasons encountered at the time of surgery, such as unusually large vasal segments removed at the time of vasectomy or very high vasectomy site above the level of the scrotum that the vasectomy reversal may not be able to be performed.
4. In authorizing John S. Gatewood, MD, to perform this procedure, I understand that he will be assisted by other health professionals, an anesthetist and such others, as he considers necessary in my care. I agree to their participation in my care.
5. Any tissues or parts surgically removed may be retained or disposed of in accordance with customary practice to comply with state and local standards.
6. I agree to being photographed and for inclusion of the photos in my medical record. These photograph(s) will be protected and released in accordance with HIPAA regulations.

I certify and acknowledge that I have read this form, that I understand the risks, alternatives and expected results of this procedure and that all of my questions have been answered fully to my satisfaction.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time am/pm

\_\_\_\_\_  
Date of Surgery