CONSENT TO SURGICAL PROCEDURE

VASECTOMY

Patient Name and Surname: _____

Doctor Name and Surname: _____ Date: _____

I, the undersigned declare that I have read this document and fully understand its contents.

I give consent for the following procedure to be performed on me:

Bilateral Vasectomy (Removal of a small piece of the vas deferens from both sides)

The full implications and possible complications of the procedure have been explained to me.

I understand the possible risks, of which the most common include:

- Infection, requiring antibiotics and further treatment.
- Bleeding, which may require a return to the operating room. Bleeding is more common if a patient has been taking blood thinning drugs, including aspirin.
- Rarely, during the operation, a few men may experience a slowed heartbeat and may feel faint.
- After the operation, you may develop a bruise in the scrotum that may take up to several weeks to resolve.
- There is a very small chance that ejaculates will never clear of sperm due to a technical failure. This will require a repeat operation.
- There is a remote chance that the vas may rejoin spontaneously, even after you have been sterile for some time (recanalization). If this happens, you may no longer be sterile.
- This operation should be regarded as permanent. Reversals can be done, but they are expensive and are not always successful.
- Occasionally scar tissue nodules (sperm granulomas) around the cut ends of the vas or in the epididymis occur. These are unlikely to cause symptoms. They may be palpable - size is only about 4mm.
- There is a small risk of long-term aching in the testicles (post-vasectomy pain syndrome). This is usually mild and responds to anti-inflammatory medication. In a few men, this can be persistent.

I understand that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth. I therefore authorize my urologist to perform such surgical or other procedures as are required according to his professional judgment.

_____	_____	_____
Signature: Patient	**Signature: Doctor**	**Date**