MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. (Place 'Y' for YES, 'N' for NO in all applicable boxes)				1b. DESCRIBE
Y	OPERATION OR PROCEDURE		SEDATION	**Anatomical Location: Left and Right Vas**
	ANESTHESIA	**N**	TRANSFUSION	**Vasectomy** **Transfusion not expected**

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language). **See attached Procedure Detail Sheet**

Which is to be performed by or under the direction of Dr., other staff and Resident team.

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.
4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.
5. Exceptions to surgery or anesthesia, if any are: None (If "none", so state)
6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which may be necessary to remove.
7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions: **Yes**
   a. The name of the patient and his/her family is not used to identify said pictures.
   b. Said pictures be used only for purposes for medical/dental study or research.
8. I understand that as indicated a Health Care Industry Representatives or other authorized personnel may be present.

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

_____
(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed:

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____

sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor or Guardian)*	*(Date and Time)*

DETAILS OF PROCEDURE/TREATMENT

(Descriptive information about the specific procedure(s)/treatment(s) being performed)

Procedure/Treatment Description
This procedure involves removing small sections of the tubes that carry sperm from the testicles to the penis.

Your doctor will first examine the scrotum. Your doctor will locate the tube (vas deferens) that carries the sperm from the testicles to the penis. A local anesthetic (numbing medication) is injected through the skin into the area around this tube. A small opening is made in the scrotum. The tube is grasped and a small piece of the tube is cut and removed. The open ends of the tube are closed. This is usually done with clips, sutures, and/or cautery (burning or searing). This will be repeated to the tube on the other side using the same opening or another opening. These skin openings may be stitched closed or left open to heal on their own.

Some time after the procedure, you will provide at least one semen sample to your doctor. This is to make sure the procedure worked. You will not be considered sterile until the sample has been examined._

Diagnosis
Desired sterility (inability to get a woman pregnant).

Benefits of treatment(s) or procedure(s)
This procedure will prevent you from getting a woman pregnant.

Reasonable risk / complications of surgical treatment(s) or procedure(s)
* Bleeding.
* Blood in ejaculate (fluid from penis during orgasm). This may last for a period of time after procedure.
* Change in lifestyle with psychological stresses, including poor sexual performance.
* Pain, numbness, swelling, weakness or scarring where tissue is cut.
* Reversing this procedure may be difficult or impossible.
* Swelling of the penis and/or scrotum.
* Abnormal collection of blood in an area. You may need drainage.
* Epididymitis. This is inflammation of the epididymis (a curved tube on top of the testicle that holds sperm).
* Infection of the wound.
* Long-term pain.
* Loss of testicle or testicle function. This may affect the ability to conceive children.
* No guarantee of infertility.
* Pain or discomfort during sex.
* Reaction to local anesthesia or other medicines given during or after the procedure.
* Granuloma. This is a lump of tissue that doesn't go away.
* Reopening of the tubes that carry sperm from the testicles to the penis. This means you may be able to get a woman pregnant.
* Damage to the blood vessels and other structures in the spermatic cord. This may lead to shrinkage or loss of the testicle.
* Complications from the anesthesia. These may include irregular heartbeat, pneumonia, collapse of part or all of the lung, stroke, and/or heart attack.
* Accidental injection of the local anesthetic into a blood vessel. This may cause allergic reaction, seizures, irregular heartbeat, cardiopulmonary arrest, and death. It may affect your brain temporarily or permanently. This may disturb heart and lung function.

Additional Risks Discussed (if applicable):

Alternatives to surgical treatment(s) procedures(s)
* Abstinence.
* Various forms of female birth control.
* Using condoms during sex.
* You may choose not to have this procedure.

Prognosis if not treatment is received
If you choose not to have this procedure, you will still be able to get a woman pregnant.

Blood Transfusion (if applicable): Transfusion not expected

Name of Interpreter (if applicable):

Procedural Time-Out (Universal Protocol checklist)

Procedure(s) to be performed is: VASECTOMY

1. Preoperative Verification Process, required for all procedures. (Check the appropriate blocks – either performed (Yes), or not applicable/required (N/A)

a.	Patent/parent/legal guardian verbally states 2 identifiers (e.g. name/SSN/birth date)	Yes	(required for all procedures)
b.	Correct name on chart/record/consent/radiographs	Yes	(required for all procedures)
c.	Consent verified for planned procedure completed accurately and signed	Yes	(required for all procedures)
d.	H&P within 30 days and updated within the 24 hours prior to procedure	Yes	N/A
e.	Patient allergies	NKDA	Reviewed and Confirmed
f.	Required blood products/implants/devices/graft material/studies/special equipment	Yes	N/A

2. Site Marking: (Check "Yes", or "N/A" if marking is not required)

a.	Patient/parent/legal guardian verbalizes and points to location of surgery	Yes	N/A	
b.	Correct surgical procedure and surgical site marked	Yes	N/A	Unable to Mark

3. Surgical Pause "Time Out" - Immediately before starting procedure

a.	Correct patient identity verbally verified by staff – use 2 pt identifiers (e.g.(name/SSN/birth date	Yes	(required for all procedures)
b.	Correct side, and site and level marked	Yes	N/A
c.	Any required blood products, implants, devices and/or special equipment is available	Yes	N/A
d.	Correct patient position	Yes	N/A
e.	Labeled diagnostic and radiology images displayed	Yes	N/A
f.	Antibiotic administered	Yes	N/A
g.	Mark is visible after drape – make incision *only* if initials are visible and correct Or provider has specified "Unable to Mark" above	Yes	N/A
h.	All members of the procedure team are in agreement on procedure to be performed or a patient safety Time-Out is called (see table below)	Yes	N/A

• Site is confirmed with patient but unable to mark:	# Critical Steps Reviewed:

• Patient refuses marking
• Premature infant
• Technically/anatomically not able to be marked
• Single midline organ
• Site not predetermined – interventional procedures, spinal analgesia, etc.
• Teeth
  • Review the dental record including the medical history, laboratory findings, appropriate charts, and dental radiographs.
  • Indicate the tooth number(s) or mark the tooth site or surgical site on the diagram of teeth or radiograph to be included as part of the patient record.
  • Correct site verified 2nd time following single tooth isolation
	• Surgeon Review
	  • Critical or unexpected steps
	  • Operative duration
	  • Anticipated blood loss
	• Anesthesia Review
	  • Previous issues with anesthesia or peri-operative bleeding
	  • Airway status
	  • Any patient-specific concerns
	  • FSBG or b-HCG
	• Nursing Review
	  • Sterility confirmation (including indicator results)
	  • Equipment issues or any concerns

Verified by: _____ **Date & Time:** _____

☐ **Exception to time-out documentation above: By checking this block, I certify that I have performed and documented the required time-out procedures, as described above, in another document or format. (This includes either a written or electronic pre-operative nursing form, procedure note, or clinical / progress note, which is readily available for verification.)**

Provider / Assistant signature: _____ **Date & Time:** _____

Register No. Clinic/Ward No.

PATIENT'S INFORMATION: (For typed or written entries give:
Name – Last, First MI, grade, rank, rate, SSN, DOB, and hospital or medical facility)