Patient ID# ____________________

AUTHORIZATION FOR STERILIZATION
(VASECTOMY)

I, ____ authorize Dr. Carris, Cohn, Coons, Crissey, Derksen, Thomasch, Ferguson, Simon, Thayer to perform a vasectomy on myself. I understand that the operation consists of removing a section of the vas (tube that carries sperm). I understand that once a vasectomy is performed, it may not be reversible, despite operations that are designed to do that.

I also understand that the operation is not guaranteed to result in sterilization (inability to father children). In a very small percentage of patients, the divided ends of the vas have reopened by themselves resulting in an unexpected pregnancy. I understand that other complications such as hemorrhage, infection, pain, and swelling rarely occur.

I understand that this is a 45 minute appointment. If the appointment needs to be changed or canceled, we require 48 hours advance notice. If this notice is not given, there will be a $100 charge. We regret the necessity for this charge however, we cannot schedule another surgery on such short notice.

WARNING

If you have questions as to the risks, complications or hazards of the proposed surgery, ASK NOW BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTAND THIS FORM.

Number of children______ Medications _____________________
Allergies ____
Have you ever had any of the following:

___Chest Pain
___Kidney Infection
___Rheumatic Fever
___Shortness of Breath
___Venereal Disease
___Fainting Spells
___Bleeding Problems
___High Blood Pressure
___Asthma
___Diabetes
___Epilepsy

___Yes, I am required to take an antibiotic prior to any dental work I may have done.

_________________________ _________________________
Patient Consenting Wife (If Appropriate)

_________________________ _________________________
Physician Signature Date