NAU UROLOGY SPECIALISTS

O 512 238 0762
F 512 341 7370
northaustinurology.com

Patient Procedure/Treatment Consent Form
P-Shot

Patient Name:_____ DOB: _____

I hereby authorize and direct _____ and assistants, as necessary to perform quality care, to perform the following procedure/treatment on me:

✔ P-Shot

I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I have not received any promise, guarantee or warranty that my undergoing the P shot procedure will achieve a particular result. I fully understand that individual results do vary, and that NAU Urology Specialists assumes no responsibility for failure to achieve a desired result. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my interests and where delay might impair my health.

I authorize NAU Urology Specialists to treat my condition, including performing further diagnosis and the procedures described below, and taking any needed photographs.

I understand the proposed P shot procedure(s) to be: a procedure for rejuvenating and strengthening the penis, using blood-derived growth factors (platelet-rich fibrin matric (PRFM), platelet-rich plasma (PRP) injections.

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- Bleeding
- Infections
- Urinary Retention
- No effect at all
- Allergic reactions
- Mental preoccupation of the penis
- Sexual function alteration

- Increased/worsening nocturia (waking up several times at night to urinate)
- Change in urinary stream
- Need for subsequent surgery
- Alteration of penile sensations
- Scar formation (penile)
- Local tissues infarction and necrosis
- Fatigue
- Alteration of bladder dynamics
- Post-Operative pain
- Prolonged pain
- Intractable pain
- Alteration of the male sexual response cycle
- Failed procedure
- Varied results
- Psychological alterations
- Relationship problems

I also understand that there may be other RISKS OR COMPLICATION, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

I understand that the use of PRP in this procedure is an "off-label" use, and no promise or representation, guarantee or warranty regarding its use, benefit or the quality is made. No representation that the use of this product and this procedure is approved by the FDA or any other agency of the federal or state government is made. I understand the alternatives to the proposed procedures and the related risks to be: do nothing.

CONSENT FOR ANESTHESIA

When local Anesthesia and/or sedation is used by the physician: I consent to the administration of such local anesthetics as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine.

PATIENT CERTIFICATION

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have ready or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to

Patient/Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____