NAU UROLOGY SPECIALISTS

Patient Procedure/ Treatment Consent Form

Vasectomy

Patient Name: _____ DOB: _____

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

- Nausea and vomiting
- Bruising or tenderness of the veins or vessels into which the medications are placed
- Depressed respiration
- Extremely remote possibility of complications may require transport to a hospital for treatment.
- Epididymitis (infection of the epididymis which may or may not be related to the surgery itself
- Buildup of sperm at the end of the cut vas deferens (sperm granuloma)
- Infection at the incision site
- The ends of the vas deferens may rejoin themselves (recanalization), they may not work initially
- Development of main months after the procedure

I acknowledge that no guarantees have been made to me as to the outcome of procedure(s) and/or treatment(s). I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Witness Signature: _____

Date: _____