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CONSENT FOR VASECTOMY

I hereby authorize Arif H Agha, MD and/or assistants as may be selected by said physician to treat the following condition(s)

DESIRE TO BE INFERTILE

The procedures planned for the treatment of my condition(s) have been explained to me by my physician and are listed below

REMOVAL OF A SMALL SECTION OF VAS FROM BOTH SIDES
BILATERAL VASECTOMY

Possible risks associated with this procedure(s):

INFLAMMATION OR INFECTION OF SKIN, TESTICLE(S) OR EPIDIDYMIS
RE-JOINING OF VAS ENDS RESULTING IN FERTILITY & PREGNANCY
CHRONIC TESTICULAR DISCOMFORT OR SPERM GRANULOMA
DEVELOPMENT OF ANTI-SPERM ANTIBODIES
UNRECOGNIZED LONG TERM EFFECTS OF VASECTOMY
LONG TERM EFFECTS OF VASECTOMY ARE STILL UNCERTAIN AND MAY BE ASSOCIATED WITH INCREASED RISK OF PROSTATE CANCER

ALTERNATIVE THERAPY: OTHER FORMS OF CONTRACEPTION, MALE OR FEMALE

I certify that this two (2) page form has been explained to me and that I have read it, or have had it read to me and that I understand its contents.

Patient Signature_____Date_____Name_____

Witness/Spouse Sign_____ Date_____ Name _____

Illinois State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

The information that follows is the text from a standardized Surgical Consent form. It is used for the most minor of procedures and the most complicated and serious ones. It is not meant to frighten you but rather to inform you that ALL procedures carry some risks. Many operations, for instance, have only the remotest chance of needing blood transfusions, but yet blood transfusions are mentioned. This form hopefully will allow you to better understand your upcoming operation. If you don't understand something -ASK.

I recognize that, during the course of the operation, post-operative care, medical treatment, anesthesia or other procedures, unforeseen conditions may necessitate additional or different procedures than those set forth. I therefore authorize my above physician, and their assistants or designees, to perform such surgical or other procedures as are in the exercise of their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I realize that in those cases where an incision is needed, infection, incisional pain, or hernia formation (weakness or bulging) can occur, and may require further treatments or procedures.

I realize that the list of risks and complications on this form may not include all possible or known risks of the intended surgery but is a list of the more common or severe ones. I realize that new risks may exist or may be found in the future that are not mentioned on this consent form.

I acknowledge that no warranty or guarantee has been made to me as to the results of my procedure or cure of my condition.

I consent to the administration of anesthesia by my attending physician, an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involves risks and potential complications and possible serious damage to vital organs such as the brain, heart, lung, liver and kidney, and in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

I consent to the use of transfusions of blood and blood products as may be deemed necessary by my physicians. I understand that diseases can be transmitted via these blood products, including AIDS and hepatitis.

I acknowledge that any tissues or parts removed surgically may be disposed of by the hospital or physician in accordance with accustomed practice.

I understand that any aspect of this consent form that I do not understand can be explained to me in further detail by asking my physician(s) or their associates.

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

Patient or Guardian Initials _____

The medical procedure or surgery stated on this form (page 1), including the possible risks, complications, alternative treatments (including non- treatment) and anticipated results, was explained by me to the patient or his/her representative before the patient or his/her representatives consented.

Physician's Signature _____Date_____