North Austin Urology

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Patient Information and Consent Form

Vasectomy

Partial Bi-lateral Vasectomy is a procedure where the tubes that carry sperm from the testicles (vas deferens) are cut for the purpose of sterilization (to prevent pregnancy). The procedure is considered permanent even though it may be possible to reverse the procedure.

- During the procedure the surgeon will make an incision in your scrotum. The vas deferens are then cut and sealed off at the ends. A segment of the vas deferens may be removed.
- The procedure is performed in the office under local anesthetic and lasts about an hour.

Possible complications include:

- Painful swelling of the tesiticles (epididymitis).
- Build up of sperm at the end of the cut vas deferens (sperm granuloma).
- Bleeding within the scrotum (hemorrhage).
- Abscess within the scrotum.
- The ends of the vas deferens may rejoin themselves (recanalization).
- Failure of partial bilateral vasectomy.

<u>Please observe the following Pre-Operative Guidelines:</u>

- The following medications should be **Avoided One Week Prior to the Date of Surgery**: All aspirin (ASA) or NSAID's (Motrin, Advil), Coumadin, Lovenox, Celebrex, Plavix (Please contact us if you are unsure about which medications to stop, Do not stop any medication without contacting your prescribing doctor).
- One day before the surgery begin taking your prescribed antibiotic.
- On the day of the surgery, shave ALL hair from the upper scrotum (area just under the penis) and thoroughly was the area to remove all remaining hair.
- Have nothing by mouth 3 hours prior to your procedure unless otherwise instructed by the anesthesiologist.

After the Procedure:

- Please wear your athletic support immediately after surgery to reduce swelling and hold bandages in place.
- You can expect to have some pain and bruising after the procedure. Agressively ice your scrotum for the first day and a half after surgery. You may remove your dressing and bathe one day after the procedure.
- Take it easy for 48 hours after the procedure and avoid all heavy lifting, pushing or straining.
- Sexual activity and athletics may be resumed 7 days after surgery; use discretion.
- 15 to 20 ejaculations are necessary to clear your reproductive system of any remaining sperm this will take about 6 to 10 weeks to accomplish (2 a week).
- **Continue to use birth control** until you have had your semen analyzed twice (at 6 and 10 weeks after the procedure). You will be given two specimen cups to return to us with the specimens. No sperm must be present at the time of collection to render you sterile.
- Please contact us if your pain continues to increase, you observe large amounts of blood or heavy bleeding, or if you have a fever above 101 degrees.
- It is also necessary to schedule follow-up visits with us to assess your progress between one and two weeks after the procedure.

Consent for Vasectomy:

I, hereby authorize Sandeep G. Mistry, M.D. M.P.H. of North Austin Urology and such assistants as may be required to perform a Vasectomy. I accept the treatment recommendation, and my physician has informed me of:

- The nature of treatment.
- Reason for treatment.
- The expected results.
- Alternative treatment choices.
- Benefits of proposed treatment and non-treatment.
- Possible risks and complications.

I have been given the opportunity to ask questions and vocalize concerns to my satisfaction.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Name: _____
Signature: _____
Date: _____

Pre-Vasectomy Quiz

To be completed by the patient in his own handwriting:

1. I have read the vasectomy information sheet which I have initialed, I understand it, and have no additional questions at this time.

YES or NO

2. Can this operation fail?

YES or NO

3. Is it possible that this operation may work initially and then fail later within the first year?

YES or NO

4. How will I know that the operation is a success? _____

5. When should I bring in semen samples for analysis? _____

6. When will it be safe to have intercourse without using some form of birth control?
_____

7. I can have pain in my testicles or epididymis* months afterwards as a result of the procedure.

True or False

Epididymis- A long, narrow, convoluted tube, part of the spermatic duct system, that lies on the posterior aspect of each testicle, connecting it to the vas deferens.

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Informed Consent for Conscious Sedation

TEXAS 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.

I understand that conscious sedation may be a necessary part of the course of treatment of the following condition(s) which has (have) been explained to me: _____.

I have been informed how conscious sedation is performed. I understand that all sedation and anesthesia medications involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney, and that in some cases use of these medications may result in paralysis, cardiac arrest, and/or brain death from both known and unknown causes. I have been informed of possible alternative forms of treatment, including non-treatment:

I understand that, during the course of the conscious sedation, operation, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than set forth above. I therefore authorize my below-named physician, and his/her assistants or designees, to perform such procedures that are considered necessary and desirable, in their professional judgment. 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 consent to the administration of sedation or anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary.

I hereby authorize Dr. Sandeep Mistry and/or such associates or assistants as may be selected by said physician to administer conscious sedation.

I CERTIFY THAT MY PHYSICIAN HAS INFORMED ME OF THE NATURE AND CHARACTER OF THE PROPOSED TREATMENT, THE ANTICIPATED RESULTS, THE POSSIBLE ALTERNATIVE FORMS, ANY RECOGNIZED SERIOUS POSSIBLE RISKS AND COMPLICATIONS OF THE PROPOSED TREATMENT AND OF ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT.

I CERTIFY I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, I HAVE HAD ALL ASPECTS OF THIS MEDICAL TREATMENT EXPLAINED TO MY SATISFACTION.

I HAVE READ AND UNDERSTAND THIS FORM. I AM THE PATIENT OR THE LEGALLY AUTHORIZED PERSON TO SIGN ON THE PATIENT'S BEHALF.

_____ _____

Signature of Patient Date

_____

Witness