Philadelphia Urology Associates

Bruce B. Sloane, MD, FACS

Patient Name: _____

Procedure Date: _____

DOB: _____

Vasectomy Consent

I hereby authorize Dr. Sloane to perform upon me: Vasectomy for elective sterilization.

I understand that the following are risks and complications of the above-mentioned operation. Including but not limited to: post-operative bleeding, post-operative hematoma that may require surgical evacuation, post-operative acute or chronic pain that may last for > 6 months to years, reconnection of severed vas deferens that may result in pregnancy, persistent sperm up to one year that may require additional surgical intervention. Testicular and Scrotal swelling. It may take 3 to 6 months, for sperm to disappear.

The nature and purpose of the operation, possible alternative methods of sterilization, the risks as noted above, the possibility of complications and the consequences, including not being able to father any children, of the operation have been fully explained to me. I acknowledge that no guarantee or assurance has been made to the results that may be obtained.

I certify that I have read and fully understand the above consent statement, which has been preceded by an explanation by Dr. Sloane.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO MAKE SURE THAT I HAVE COVERAGE FOR THIS PROCEDURE (CPT CODE: 55250). IF NOT COVERED, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness Signature: _____ Date: _____