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UROLOGY INSTITUTE OF THE SOUTH BAY A Medical Group

A Division of U.S.S.C.

CONSENT FOR VASECTOMY

I, the undersigned do hereby request and authorize _____ M.D. to perform the operation called "Bilateral Vasectomy" upon me for the purpose and with the intention of producing sterility, and that shortly thereafter, I will be unable to become a father or produce children.

The operative procedure and probable complications, including the possibility of recanalization, have been explained and all questions concerning the operation and possible complications have been answered. I also understand that in some instances, some operations are not immediately successful; therefore, I realize that after the operation, methods of contraception (birth control) must be continued until two examinations of the semen have documented the absence of sperm.

I further understand that once performed, such operations are generally permanent and that fertility is difficult, and sometimes impossible, to restore by any method. I understand that no organs are to be removed and this operation does not alter existing libido or potency (sexual desire or ability).

With my signature below, I attest to have personally and voluntarily sought this operation.

Patient signature _____

Date _____

Print patient name _____

Witness _____