INFORMED CONSENT FOR CIRCUMCISION

I hereby request and authorize Dr. H. Reed, and his assistants to perform the urological operation entitled "circumcision". Dr. Reed has discussed his case experience with me and has commented on: a) surgical techniques; b) the anticipated (post-operative course); c) related risks.

I am aware that I will not be able to function sexually for at least six weeks and that my sutures will need to be removed in 12 days. During this process some degree of inflammation is noted in the incision area. Swelling, black and blue marks (ecchymoses) are to be expected to some degree. Also, there may be some loss of sensation in the surgical area or distal to that (towards the head of the penis. Usually this numbness will return to normal after a few months but no guarantee can be made that sensation will be perfectly the same as prior to surgery. Other complications include delayed or prolonged bleeding in the incisional area, infection, suture reaction, removal of not enough skin, removal of too much skin, persistent swelling on the shaft, irregular result, uneven contours, incisional separation, delayed wound healing, and prolonged discomfort.

I understand during the procedure Dr. Reed may employ intra-venous tranquilizers or analgesics (pain killers) that may have a sedating effect when requested by the patient. If so, you may not drive for 24 hours and make provisions for travel. Regardless, I will remain in the recovery room from 1 to 2 hours before driving home or operate any vehicle. If requesting the services of an anesthetist there is an additional fee of $600.00 and related supplies and you will not drive home or operate any vehicle for at least one day. Please come with a friend if anesthesia is administered.

I am aware that Dr. Reed has elected under the provisions of Florida State Law not to carry professional liability insurance.

I understand that Dr. Reed, during the operative procedure, will be occupied totally with surgery and that the administration of anesthesia is an independent function.
I give permission for genital photography before, during, and after the procedure, and agree that these photographs shall be property of Dr. Harold M. Reed, and may be utilized for scientific reasons or in a manner directly related to the practice of medicine.
I have read and signed the above consent in the presence of a witness whose signature appears below, after I have had an opportunity to question Dr. Reed regarding any unfamiliar medical terminology.

Dr. Reed has given me a choice as to whether I wish to have my foreskin sent to the laboratory for pathological confirmation and I anticipate an independent charge to me for this examination.

Please sign #1 or #2…

1. I do not wish to have the removed tissue analyzed by a pathologist yes:_____ no:

2. I request analysis by a pathologist of tissue removed and understand if insurance coverage is not available, I accept responsibility for the pathologist's lab fee for this service and instruct Doctor Reed's office to provide the laboratory with my billing address. Initial:_____

I have personally discussed with the patient, the above described proposed surgery, its risks and potential complications, as well as the alternatives available.

Please initial patient preferences:
1. I want the frenulum or cord removed Yes: No

2. I want an (oblique art) cut paralled to the rim or (corona)
Yes :_____ No:_____ or
I want the cut perpendicular to long axis. Yes:_____ No:___

3. I want the skin tight:_____ moderate: loose:_____

4. I want the cut low:_____ moderate: _____ high:_____

Please note high cuts are associated with prolonged swelling for weeks.
Low means closer to the head of the penis. High means closer to the pubis.

PATIENT SIGNATURE:_____DATE:_____