VASECTOMY CONSENT FORM

Patient Name: _____
Please Print

I hereby request and authorize the physician to perform upon me the procedure known as a bilateral vasectomy.

I understand that bilateral vasectomy means the removal of a segment of each vas deferens, each of which conducts sperm, and that the purpose of this procedure is to cause me to be sterile, i.e. unable to father children once my semen specimens are cleared of sperm.

I agree that I will present specimens of my semen following the procedure so that the absence of sperm in the semen can be determined. I understand that contraception shall not be abandoned until I am advised by the physician that the procedure has in fact resulted in sterility.

I understand that the procedure is intended to be irreversible, but not withstanding that this is the purpose and intent, it may not have this effect. That is, the result of sterility is not guaranteed, and I may not be sterile as a result of the operation.

I understand that the risks include, but are not limited to, bleeding, infection, pain, and failure.

I hereby release the physician and Ironwood Family Practice from any and all claims arising out of or connected with the performance of this procedure.

I certify that I have read and understand the explanation above and the details of vasectomy.

Signature of Patient: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

I am the wife of _____. I understand that my husband has asked the physician to perform a bilateral vasectomy procedure on him. I have read the consent which my husband has signed and realize the procedure will not take effect for some time after it is performed, but thereafter it will be very unlikely that my husband will be able to cause me to become pregnant. I have no objection to this procedure and agree that I will not assert any claim against the physician and Ironwood Family Practice on the basis of the procedure performed and that I release him from any and all liability arising out of or relating to the procedure.

Name of Patient's Spouse: _____
Please Print

Signature of Patient's Spouse: _____ **Date:** _____