INFORMED CONSENT FOR BILATERAL ORCHIECTOMY

1. I hereby request and authorize Dr. Harold M. Reed, and his designated urological associated and surgical technicians, to perform the urological operation entitled "Bilateral Orchiectomy" (or removal of the testicle and cord).

2. I have given careful consideration to the implications of this type of operation as far as the irreversible result and the change of my life style both mentally and physically.

3. The intended area of the incision in the scrotal area has been shown to me, as well as a description of the procedure with reference to my personal anatomy.

4. I will abstain from sexual activity for 4 weeks following surgery.

5. Surgical risks include swelling, bleeding, infection, and post-operative pain.

6. I have not been treated by a psychologist, psychiatrist, or physician for any emotional disorder. I do not believe I have any significant emotional disorders presently, if so I have been cleared for this procedure.

7. The administration of anesthesia, should an anesthetist or anesthesiologist be used, is an independent function and any questions regarding anesthetic management should be addressed directly to the anesthetist. A remote complication of general anesthesia is inadequate intubation, and a remote complication of spinal anesthesia is inadequate pain control. Additional Fee: $650. Must request 2 weeks in advance.

8. I have had ample opportunity to discuss the intended procedure with Dr. Reed and ask and have answered any questions that I might have.

PATIENT SIGNATURE: ______________________________

DATE : ________________________ WITNESS: ____________________________

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

HAROLD M. REED, M.D. P.A.
(conorchiectomy)