



SURGERY CONSENT

I hereby authorize Michael P. Daniel, M.D., of Daniel Urological Center, Inc., and any assistants as may be found necessary by said physician, to perform a **vasectomy reversal**. This is a reversal of a previously desired permanent sterilization procedure.

The purpose of this procedure is to attempt to restore continuity of the vas and to facilitate the possibility of future fertilization and pregnancy. This will be performed by reconnecting the ends of the vas to each other or by connecting the end of the vas to the epididymis. When the latter is felt beneficial, usually there is a lower probability of future pregnancy. The choice of which of these procedures is best for one individual may be unclear and there may not be a single best answer. This choice will also vary between surgeons. I have been advised based on the information available to date as to how this decision should best be made. I acknowledge that I have discussed both of these options extensively with Dr. Daniel before this procedure and that he has my permission to proceed with either of these approaches as seems necessary or as per our discussion. Not all procedures are successful with regard to either the goal of reestablishing continuity or pregnancy. Pregnancy is less often achieved than the restoration of continuity, and even when sperm become present in the ejaculate, pregnancy still may not occur. Sometimes this involves female factors as well.

Most if not all patients will experience swelling and discomfort. Some degree of pain is expected following this procedure. Significant bleeding, testicular shrinkage, infection, and testicular loss can occur but are unusual. Reaction to a medication received either before or after the procedure may occur based on individual allergy. The overall quality of the sperm is not changed by this procedure. It will take a minimum of about 3 months following the procedure before pregnancy is possible, however, as before the original vasectomy, pregnancy may not occur immediately or at all.

I have met with Dr. Daniel to discuss this procedure at length and accept the treatment as described above, realizing that no guarantee can be given with regard to outcome. I further understand that I am financially responsible for this procedure. I understand that this is not a procedure covered by health insurance at this time. I have been allowed time to ask and have answered my questions regarding this procedure and our expectations. The specific risks, options, complications, and expected outcomes have been discussed to my satisfaction and surgical consent is thus given as noted by signature below.

SIGNATURE

DATE

WITNESS

MICHAEL P. DANIEL, M.D.