First Hill
SURGERY CENTER

Adult Circumcision
Consent Form

Patient Name: _____ Date of Birth: _____

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. _____ to perform an **Adult Circumcision** upon me. I understand the procedure is to be performed at First Hill Surgery Center. This has been recommended to me by my physician in order to **remove the prepuce (foreskin) that covers the glans penis.**

I understand that the procedure or treatment can be described as follows:
The foreskin is cut and removed. Bleeding vessels are cauterized (burn with a heated scalpel) or tied with a suture. Sutures are then placed in the skin around the full circumference of the penis.

This procedure requires general anesthesia which will be administered by a qualified anesthesiologist.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Decreased risk of infection, ability to expose glans, improvement in urine stream

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

- *Hematoma.* This happens when a small blood vessel continues to ooze or bleed after the procedure is over. The result is greater swelling and bruising because the blood may be caught under the suture line. This almost always resolves over time with compresses. If the hematoma does not resolve itself, an additional procedure to evacuate the clots (an incision to allow drainage) may be required.
- *Infection.* Infection is possible in any procedure. Usually, local wound care and antibiotics are sufficient. Occasionally, an infection requires partially opening the wound to drain. Infections are most common in patients who have diabetes. Signs of infection are; unusual redness, increased pain, and/or whitish to yellowish discharge from between the sutures.
- *Injury to the Glans Penis.* This can be seen in patients with severe phimosis (complete inability to pull the foreskin back) and history of infections. The foreskin can be stuck to the glans. While every precaution is taken to separate the two, we can sometimes cause an abrasion (scraping) or laceration (cut) to the glans. Rarely, sutures may be needed to the area.

- *Decreased sensation of the head of the penis*

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 **TISSUE DISPOSAL/PATHOLOGY**

Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.

5 **MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to dorsal slit of prepuce and no surgery. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Adult Circumcision** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ Date: _____ Time: _____

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____