



Probus Surgical Centre

*"To improve the health and well-being of those we care for"*

## REQUEST BY A PATIENT TO STERILISATION BY VASECTOMY

**I NAME:**

**NHS NO:**

**D.O.B:**

Hereby consent to undergo the operation of vasectomy under local anaesthetic, the nature and effect of which has been explained to me by my Surgeon. I have been told about and considered alternative methods of contraception.

I confirm that I have received, read and understood the information leaflet provided. I have been told that the object of the operation is to render me sterile and incapable of further parenthood and the effect of the operation may be irreversible. I understand I should not abandon other methods of contraception, prior to receipt of written notification that at least one sperm count at 16 weeks after my vasectomy has proved clear, or special clearance has been given, which may take up to 7 months.

I understand that the operation may occasionally fail (up to 2% chance) because the vas re-joins spontaneously in the first 16 weeks. I have been told of the following possible risk and benefits. Any complications may require further medical treatment, hospitalisation or further surgery.

**Benefits:** No General Anaesthetic Complications  
Sterility

**Risks:** Haematoma (1%)  
Post Vasectomy/Scrotal Pain (typically 0.5% but up to 5% has been reported)  
Infection (1%)  
Early failure (In the first 16 weeks up to 2%)  
Late failure (Any time after being given the 'all clear' 1:2000)  
Testicular atrophy (Very rare- loss of a testicle due to interruption of blood supply)

### Statement of Patient

I agree to the procedure or course of treatment stated on this form. I had the opportunity to discuss the details of the procedure prior to the operation.

**Patient's Signature:** .....

**Date:** .....

**Printed Name:** .....

### Surgeon's Confirmation

I am satisfied that the patient understands what is proposed and is happy to proceed to a vasectomy.

**Clinician's Signature:** .....

**Date:** .....

**Clinician's Printed Name:** .....

### Statement of Interpreter (Where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he can understand.

**Signed:** .....

**Date:** .....

**Interpreter Printed Name:** .....



To get this information in another format call:  
01726 885104

Reviewed June 2017 GL/RSM



To get this information in another format email:  
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