Vasectomy Consent Form

Patient Consent
Name: _____ Phone: _____
Address: _____
ID No.: _____ Chart No.: _____
I, the undersigned…
☐ Verify that I am over _____ years of age.
☐ Understand the pain, discomfort, risks, benefits and recovery time associated with this procedure.
☐ Understand that this procedure may not be reversible.
☐ Understand that after this procedure takes effect I will not be able to father children.
☐ Have been informed of other birth control options, including _____
☐ Have rejected the aforementioned temporary options and have chosen a vasectomy.
☐ Understand that I have _____ days until the surgery and that I can revoke my consent at any time without penalty or loss of benefits
☐ Understand that the procedure may take up to 6 weeks and 15 ejaculations to take effect and that I am advised to use contraceptives until a test result verifies that I am no longer producing sperm.
☐ Understand that the procedure may not work and that I may retain fertility or become fertile again in the future.
☐ Verify that the doctor has explained the aforementioned information to me in detail and has answered all questions I had.

_____ _____

Patient Signature **Date**

Physician Statement
Doctor Name: _____ Hospital: _____
I, the consulting physician…
☐ Hereby state that to the best of my knowledge, the patient is over _____ years of age, mentally sound and physically capable of undergoing the surgery.
☐ Explained the resulting benefits, risks, pain and discomfort of this procedure to the patient.
☐ Believe that the patient understands that the procedure may result in permanent, irreversible sterility but may also result in sustained or returned fertility.
☐ Believe that the patient understands the waiting period and test required for full sterility assurance
☐ Ensured that the patient voluntarily consented to this operation and understands that consent can be revoked at any time.
☐ Swear that I have explained the aforementioned information to the patient in detail and have answered all questions asked.

_____ _____

Physician Signature **Date**

Witness Statement
I, _____ , hereby swear and confirm that I witnessed the physician inform the patient of the aforementioned information and that the witness did sign the document in his or her own hand.

_____ _____

Witness Signature **Date**