

THE ELLIOT-SMITH CLINIC
Churchill Hospital, Headington, Oxford OX3 7LJ
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General & Clinical Enquiries:

12 noon – 3.00pm Mondays Tuesdays Thursdays Fridays except for Bank Holiday periods
 (For change of appointment please telephone Tuesdays and Thursdays only)

PATIENT APPLICATION/CONSENT TO AN OPERATION FOR PRIMARY MALE STERILIZATION

To the Surgeon in Charge

1. PATIENT (first line to be completed in BLOCK CAPITALS)

I.....of.....
 Having read and understood the current leaflet entitled Male Sterilization Explained consent to undergo the operation of vasectomy, the nature and effect of which have been explained to me by Dr..... I have been told that the intention of the operation is to make me sterile and incapable of fathering a child, and I understand that the effect of the operation may not be reversible. I understand also that there is a very small possibility that I may not become or remain sterile. I understand also that two consecutive negative sperm counts must be obtained before I abandon other methods of contraception. I also consent to the administration of a local anaesthetic. No assurance has been given to me that the operation will be performed by a particular surgeon.

Date.....Signed.....

2. DOCTOR

I confirm that I have examined this patient's genitalia, explained to him and his partner the nature and effect of his operation, and I know of no contra-indication due either to physical abnormality, psychiatric disorders or drug therapy.

Additional information

Hernia: Yes/No	Varicocele on standing: Yes/No	Height
Orchidectomy: Yes/No		Weight
Orchidopexy: Yes/No	Other: Yes/No	BMI

Any other scrotal surgery/injury or scrotal pain – please state:

Do you wish this couple to be further counselled by one of the Clinic Surgeons. Please indicate: Yes/No

Date.....Doctor's Signature.....

Address

CONFIRMATION OF CONSENT (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance). On behalf of the team treating the patient, I have confirmed with the patient that he has no further questions and wishes to proceed with the operation.

Signature of a member of the healthcare team.....Date.....

Name (PRINT).....Surgeon/Nurse

Signature of patient.....Date.....

N.B. WILL THE PATIENT PLEASE COMPLETE THE REVERSE OF THIS FORM

NOTICE TO PATIENTS

PLEASE ENCLOSE A STAMPED SELF-ADDRESSED ENVELOPE WITH THIS COMPLETED FORM AND THE FEE to be returned to **The Elliot-Smith Clinic, Churchill Hospital, Headington, Oxford OX3 7LJ** Cheques should be payable to E-S Clinic. This consent form must be signed by you and your doctor, and completed by you.

Appointments are usually given 3-8 weeks ahead, so please let us know any dates during the next two months when you will not be available. An appointment will then be sent to you. Should you postpone or cancel your appointment, the majority of your fee will be refunded **only if you give 14 clear days' notice.** If less than 14 days notice is given an administration fee will be retained, this being £100.00 at the current time. The rest of your fee will be refunded. Please complete the following details in the space provided.

Your age..... Date of birth..... Occupation.....

Your wife/partner's age..... Date of birth..... Occupation.....

Years of present marriage/relationship.....

Wife/Partner's name.....

Ages and sexes of children a) Yours by this marriage/relationship.....

b) Yours by previous marriage

.c) Your wife/partner's by previous marriage.....

d) By adoption

Is your wife/partner pregnant? Yes/No. If yes give expected date of delivery.....

What is your usual method of contraception?.....

Is your wife due to have a gynaecological operation? Yes/No

If yes state nature of operation.....

Give details with date(s) of any operation(s) or condition(s) you have had in the groin or scrotum

.....

Have you had severe mumps affecting the testicles? If yes give date.....

Give details of any medicines you take on Doctor's prescription. (including Aspirin).....

Dates when NOT available.....

Dates preferred.....

Daytime telephone number at which you may be contacted:

home:..... Mobile..... work:.....

E-mail address

Additional information.....

*NB Wherever wife appears on this form it is taken to include present regular partner/common law or future wife (please state which applies) Operations are performed on late Tuesday pm, Friday pm and on occasional Saturday morning.

Elliot-Smith Clinic Ltd., inc. England Reg No 1792490. Reg.Off. 126 High Street, Oxford, OX1 4DG
(NOT FOR CLINICAL ENQUIRIES)

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