

THE REED CENTRE
for Ambulatory Urological Surgery

1111 KANE CONCOURSE
BAY HARBOR ISLANDS, FLORIDA 33154
Phone (305) 865-2000 / Fax (305) 865-2002

INFORMED CONSENT FOR CIRCUMCISION

1. I hereby request and authorize Dr. Harold Reed, and his assistants to perform the urological operation entitled "circumcision". Dr. Reed has discussed his case experience with me and has commented on: a) surgical techniques; b) the anticipated (post-operative course); c) related risks.

2. I am aware that I will not be able to function sexually for at least six weeks and that my sutures will need to be removed in 12 days. During this process some degree of inflammation is noted in the incision area. Swelling, black and blue marks (ecchymoses) are to be expected to some degree. Also, there may be some loss of sensation in the surgical area or distal to that (towards the head of the penis). Usually this numbness will return to normal after a few months but no guarantee can be made that sensation will be perfectly the same as prior to surgery. Other complications include (but may not be limited to) delayed or prolonged bleeding in the incisional area, infection, suture reaction, removal of not enough skin, removal of too much skin, persistent swelling on the shaft, irregular result, uneven contours, incisional separation, delayed wound healing, and prolonged discomfort.

3. I understand during the procedure Dr. Reed may employ tranquilizers and or anesthetic agents that may have a sedating effect. Therefore, I will remain in the recovery room from 1 to 2 hours before driving home or operate any vehicle. If requesting the services of an anesthesiologist there is an additional fee of \$400.00 and you will not drive home or operate any vehicle for at least one day. Please come with a friend if anesthesia administered.

4. I am aware that Dr. Reed has elected under the provisions of Florida State Law not to carry professional liability insurance.

5. I understand that Dr. Reed, during the operative procedure, will be occupied totally with surgery and that the administration of anesthesia is an independent function.

6. I have read and signed the above consent in the presence of a witness whose signature appears below, after I have had an opportunity to question Dr. Reed regarding any unfamiliar medical terminology. The blank space (article 2) has been filled in and initialed prior to my signing.

7. Dr. Reed has a proprietary interest in this CENTRE. You may wish to consider

alternative sites for evaluation and treatment. Pursuant to statute 64B8-9.0091, (FAC), this surgical facility is not operating as an ambulatory surgical centre (ASC) for the purposes of this consent.

PATIENT	DATE	TIME
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WITNESS

I have personally discussed with the patient the above described proposed surgery, its risks and potential complications, as well as the alternatives available.

HAROLD M. REED, M.D.
(concircumcision 10/30/95)

Dr. Reed has given me a choice as to whether I wish to have my foreskin sent to the laboratory for pathological confirmation and I anticipate an independent charge to me for this examination.

Please sign #1 or #2

1. I do not wish to have the tissue removed and analyzed by a pathologist

_____.

2. I request analysis by a pathologist of tissue removed and understand if insurance coverage is not available, I accept responsibility for the pathologist's lab fee for this service and instruct Doctor Reed's office to provide the laboratory with my billing address_____.