THE REED CENTRE
for Ambulatory Urological Surgery
1111 KANE CONCOURSE
BAY HARBOR ISLANDS, FLORIDA 33154
Phone (305) 865-2000 / Fax (305) 865-2002

CONSENT FOR CORRECTION OF PENILE ANGULATION WITH PLICATION

A revision procedure has a higher incidence of complication than the original procedure

1) I give consent to Dr. Reed and his elected assistants to perform the above operation for Penile Angulation, after learning about all the alternatives in management in such a situation, with the pros and cons and risks mentioned.

2) I understand the technique Dr. Reed will employ is to deglove penile skin and suture plicate the opposite side usually with multiple parallel permanent sutures. Although the suture knots are turned inward, they may still be palpable and rarely can be a source of annoyance. An artificial erection which will be produced either by injecting normal saline into the corpora via a butterfly needle or by injecting into the corpora vaso-dilating agents. Transient or permanent numbness may result. No promise has been made that a specific result or perfect correction of the angulation will occur following surgery. Predictably there will be some loss of length, usually 1/4 to 3/8".

3) I will not use my penis sexually for at least 6 weeks.

4) I recognize the complications that could occur include stitch reaction, infection, hematoma, loss of sensation, erectile impairment, neural and vascular injury, swelling, loss of penile length, loss of penile tissue and/or skin, prolonged pain, and under-correction or over-correction of curvature.

5) I understand the maintenance of personal hygiene, especially genital cleanliness is extremely important in preventing post-operative infection and promise to follow discharge instructions carefully.

6) I have had an opportunity to discuss the informed consent contained herein with Dr. Reed, and question him about any unfamiliar medical terminology.

7) I recognize the performance of anesthesia is an independent function. If the patient elects for a spinal type anesthetic, regional or epidural, a complication that could occur includes inadequate pain control. If the patient receives a general anesthetic, a remote complication includes inadequate intubation.

8) The information presented above by Dr. Reed although intended to be comprehensive and detailed, is not purported to cover every conceivable aspect of surgery, post operative

recovery, or complications.

9) I recognize that there are inherent risks in all surgical procedures and can appreciate the possibility of side effects and complications stemming both from the procedure and recovery there from.

10) I have had ample opportunity to discuss the intended procedure with Dr. Reed and he has answered any questions that I might have.

11) Dr. Reed has a proprietary interest in this CENTRE. You may wish to consider alternative sites for evaluation and treatment.

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.

Pursuant to statue 64B8-9.0091, (FAC), this surgical facility is not operating as an ambulatory surgical centre (ASC) for the purposes of this consent.

_____day of _____, 20_____
in the presence of witness whose signature appears below.

_____
PATIENT

_____
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.