INFORMED CONSENT FOR INSERTION OF SILICONE ELASTOMER BILATERAL TESTICULAR PROSTHESIS

1. I hereby request and authorize Dr. Harold M. Reed, assisted by his designated personnel to perform the urological operation entitled "INSERTION OF BILATERAL TESTICULAR PROSTHESIS."

2. Dr. Reed has discussed his case experience with me but has not made any promise of a specific performance or guaranteed either expressly or by implication a result.

3. Post-operative swelling of the scrotum is to be expected and may last from two to four weeks.

4. Physical trauma to the scrotum, undue pressure, and squeezing is also to be avoided. Such events during the first few weeks can lead to unwanted bruising and displacement of the silicone prosthesis.

5. I have discussed this procedure with my sexual partner or "significant other" and have gained their approval, or after careful consideration of my situation and relationship have decided to proceed.

6. I have not been treated by a psychologist, psychiatrist, or physician for any emotional disorder, nor do I believe I have any significant emotional disorder presently.

7. I have abstained from smoking for 2 weeks prior to this procedure and will abstain for 2 months following this procedure.

8. Complications of this procedure include transient loss of sensitivity, infection, testicular atrophy, capsular contracture, pain or discomfort, a collection of blood under the skin (hematoma), a collection of serum under the skin (seroma), separation of incisional margins (dehiscence), transient black and blue bruising (ecchymosis), I can appreciate that with any surgical procedure there may be unforeseen complications as well.

9. I will call Dr. Reed immediately if there are any concerns and keep my follow-up appointments with him.

10. The patient consents to medical photography before, during and after treatment, and that these photographs become the property of Dr. Harold M. Reed, and may be utilized for but not limited to publications in scientific journals, or presentation in a manner related to medical practice.

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11. I have been given a choice of anesthesia and also anesthesia providers, anesthesiologist versus CRNA versus certified P.A. The administration of anesthesia is an independent function and any questions regarding anesthetic management should be addressed directly to the anesthetist. A remote complication of general anesthesia is inadequate intubation, and a remote complication of spinal anesthesia is inadequate pain control.

12. I have seen before and after photos of anonymous patients of Dr. Reed and the areas of intended incisions have been shown to me as well by photography.

13. I, the patient, have had an opportunity to question and discuss with Dr. Reed: any unfamiliar medical terminology, as well as any concepts mentioned in this consent; any further questions relating to this procedure; anticipated post-operative course, alternatives and risks. I have not been rushed either during my consultation or before being asked to sign this consent.

14. I am aware that Dr. Harold M. Reed has elected under the provisions of Florida State law not to carry professional liability insurance.

15. I understand the maintenance of personal hygiene, especially genital cleanliness is extremely important in preventing post-operative infection.

16. I have read and understood the above described informed consent as well as Dr. Reed's list advisories on the procedure.

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.

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PATIENT DATE

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WITNESS DATE

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

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HAROLD M. REED, M.D.