Vasectomy Reversal Center of Chicago

Phone: (800) 92-VASMD Fax: (800) 57-VASMD

REGISTRATION INFORMATION

(For Vasectomy Reversal)

Date: _____ **Home Phone** _____ **Work Phone**_____ **Cell** _____

Email: _____ **Website (if applicable)** _____

Patient's Name: _____

Last First MI

Street Address_____

City_____ **State**_____ **Zip**_____ **Sex: M F Age** _____

Birth Date: / / SS #: - - Height _____ **Weight** _____

Marital status: Single Married Divorced Widowed Separated

Occupation: _____ **Employer:** _____**Phone:** _____

Spouse (or partner) Name: _____ **Age:** _____

Your Drug Store Name _____**Phone**_____

Nearest hospital name and phone number :_____(_____)_____

In case of emergency, who should be notified? _____

Phone _____ **Relationship to Patient**_____

Previous Marital History

Date married _____**Date separated /divorced/widowed** _____ **No. of children from that marriage**_____

VASECTOMY HISTORY **Date performed:** _____ **Type of Anesthesia Used**_____

Any complications No ☐ Yes ☐ If yes, please describe _____

Do you have access to the operative report from the vasectomy? ☐ Yes ☐ No If yes, please obtain this report.

Recent marriage/relationship

Date of marriage: _____

Has your present wife/fiancée/other half had children in the past? Yes ☐ No ☐

Has she been seen by a Gynecologist and have been reported to have normal genital tract for pregnancy? Yes ☐ No ☐

Consent & Payment agreement

I, the undersigned, hereby enter into a voluntary agreement with the Vasectomy Reversal Center of Chicago, an Illinois Corporation, its affiliate providers, staff, employees and facilities (hereunder referred to as "the center"). I request the center to perform my vasectomy reversal for a fee of $6,600.00 payable in advance for this elective procedure, independent of any insurance contractual obligations. I have been informed that the center and its affiliate providers do not accept insurance coverage for this procedure under this affiliation. In addition, I have been informed that if I intend to have this procedure covered by any insurance, I should choose providers other than the center and its affiliates. I request the center to perform this procedure voluntarily with my undertaking to release the center and its affiliates from any legal or insurance disputes. I agree that once the procedure is performed, the fee or any part thereof is non-refundable.

_____ _____ _____

(Signature) **Name** **(Date)**

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PAST MEDICAL HISTORY

Please answer all the questions, if possible:

Name: _____ **Date: / /**

Check (✓) if you currently have or have had in the past.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Condition
- ☐ Lung Condition
- ☐ Gastrointestinal Condition
- ☐ Eye, Ear, Nose, Throat
- ☐ Skin
- ☐ Neurologic
- ☐ Vascular
- ☐ Blood in urine
- ☐ Leakage of urine
- ☐ Kidney stones

Explain any checked condition _____

What previous SURGICAL PROCEDURES have you had?

_____

_____

What MEDICATIONS are you taking on a regular basis? Please include over-the-counter drugs such as aspirin, Motrin, and vitamins:

_____ _____ _____

_____ _____ _____

List all ALLERGIES including medications/substances:

_____

Health Habits:

- ☐ Do you or did you ever **smoke**? Yes No If *yes,* how many packs per day? No. of years
- ☐ Do you drink alcoholic beverages? Yes No If *yes,* how many drinks per day?

Have any of your blood relatives had any of the following conditions?

Diabetes Cancer Kidney Disease High Blood Pressure Other

Family History

	Father Present State of Health/ Cause of death	**Mother** Present State of Health/ Cause of death	**Spouse** Present State of Health/ Cause of death
Alive	❑	❑	❑
Deceased	❑	❑	❑

Brothers	No. Alive	Health	No. Deceased	Cause of death
Sisters	No. Alive	Health	No. Deceased	Cause of death
Children	No. Alive	Age & Health	No. Deceased	Ages & Cause of death

Welcome to VASMD

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CONSENT FOR SURGERY (Vasectomy Reversal)

I hereby authorize Vasectomy Reversal Center of Chicago and its staff Dr. Arif Agha and/or assistants as may be selected by the said physician to treat the following condition/s.

DESIRE TO RE-ESTABLISH FERTILITY AFTER PREVIOUS VASECTOMY

The procedures planned for the treatment of my condition(s) have been explained to me by my physician and are listed below

RE-JOINING OF VAS TO ITSELF (OR TO EPIDIDYMIS)

BILATERAL VASOVASOSTOMY

Possible risks associated with this procedure(s):

- NO GUARANTEE OF FERTILITY OR PREGNANCY
- NO GUARANTEE OF PRESENCE OF SPERM
- LATE SCARRING OF RE-JOINED ENDS-MAY NEED TO REDO VASOVASOTOMY
- DISCOMFORT IN TESTICLES
- INFECTION OF TESTES AND/OR EPIDIDYMIS
- INFECTION OF INCISION REQUIRING FURTHER TREATMENT
- ALTERNATIVE THERAPY: SPERM ASPIRATION FROM EPIDIDYMIS OR EXTRACTION FROM TESTES

I certify that this two (2)-page form has been explained to me and that I have read it, or have had it read to me and that I understand its contents.

Patient Signature: _____ Print Name_____ Date _____

Witness / Spouse Signature _____ Print Name_____ Date _____

Illinois State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

The information that follows is the text from a standardized Surgical Consent form. It is used for the most minor of procedures and the most complicated and serious ones. It is not meant to frighten you but rather to inform you that ALL procedures carry some risks. Many operations, for instance, have only the remotest chance of needing blood transfusions, but yet blood transfusions are mentioned. This form hopefully will allow you to better understand your upcoming operation. If you don't understand something -ASK.

I recognize that, during the course of the operation, post-operative care, medical treatment, anesthesia or other procedures, unforeseen conditions may necessitate additional or different procedures than those set forth. I therefore authorize my above physician, and their assistants or designees, to perform such surgical or other procedures as are in the exercise of their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I realize that in those cases where an incision is needed, infection, incisional pain, or hernia formation (weakness or bulging) can occur, and may require further treatments or procedures.

I realize that the list of risks and complications on this form may not include all possible or known risks of the intended surgery but is a list of the more common or severe ones. I realize that new risks may exist or may be found in the future that are not mentioned on this consent form.

I acknowledge that no warranty or guarantee has been made to me as to the results of my procedure or cure of my condition.

I consent to the administration of anesthesia by my attending physician, an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involves risks and potential complications and possible serious damage to vital organs such as the brain, heart, lung, liver and kidney, and in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

I consent to the use of transfusions of blood and blood products as may be deemed necessary by my physicians. I understand that diseases can be transmitted via these blood products, including AIDS and hepatitis.

I acknowledge that the hospital or physician in accordance with accustomed practice may dispose of any tissues or parts removed surgically.

I understand that any aspect of this consent form that I do not understand can be explained to me in further detail by asking my physician/s or their associates.

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

Patient or Guardian Initials _____

The medical procedure or surgery stated on this form (page 1), including the possible risks, complications, alternative treatments (including non- treatment) and anticipated results, was explained by me to the patient or his/her representative before the patient or his/her representatives consented.

Physician's Signature _____Date_____