Vasectomy Reversal Center of Chicago

600 Enterprise Drive, Suite 218, Oak Brook, IL 60523
111 N Wabash Street, Suite 1210, Chicago, IL 60602
425 E US Route 6, Suite A, Morris IL 60450

Phone: 800-92-VASMD
Fax: 800-57-VASMD
www.vasmd.com

PLEASE COMPLETE PAGES 1 -4 AND RETURN TO OUR OFFICE WITH PAYMENT.

REGISTRATION INFORMATION:

DATE: _____ **HOME PHONE:**_____

CELL PHONE: (Required) _____ **EMAIL: (Required)** _____

PATIENT'S NAME: _____
LAST FIRST MI

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SEX: ☐ M ☐ F **AGE:** _____ **Years** **BIRTH DATE:** _____/_____/_____ **SS#:** ☐☐☐-☐☐-☐☐☐☐

HEIGHT: _____' _____" **WEIGHT:** _____ **Lbs** **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **OTHER**

OCCUPATION: _____ **EMPLOYER:** _____ **PHONE:** _____

SPOUSE NAME: _____-_____ **BIRTH DATE/AGE :** _____

NAME OF YOUR DRUG STORE: _____ **PHONE:** _____ **FAX:**_____

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** _____ **# 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 $6,900.00 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

WHAT PREVIOUS MAJOR MEDICAL EVENTS, HOSPITALIZATIONS, AND SURGERIES HAVE YOU HAD (WITH DATES)?

_____

_____

_____

MARK WITH AN "X" IF YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

_____DIABETES	____ GASTROINTESTINAL CONDITION	____ BLOOD IN URINE
____ HIGH BLOOD PRESSURE	____ EYE, EAR, NOSE, THROAT	____ LEAKAGE OF URINE
____ CANCER	____ SKIN CONDITION	____ KIDNEY STONES
____ HEART CONDITION	____ NEUROLOGIC CONDITION	____ LUNG CONDITION
____ ERECTILE DISFUNCTION	____ VASCULAR CONDITION	____Other

PLEASE EXPLAIN ANY CHECKED:

_____

_____

WHAT MEDICATIONS ARE YOU TAKING ON A REGULAR BASIS? PLEASE INCLUDE OVER-THE-COUNTER DRUGS SUCH AS ASPRIN, MOTRIN, AND VITAMINS (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

NAME	FREQUENCY	DOSE	NAME	FREQUENCY	DOSE

LIST ALL ALLERGIES INCLUDING MEDICATIONS/SUBSTANCES (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

NAME OF MEDICINE	TYPE OF REACTION	NAME OF MEDICINE	TYPE OF REACTION

DO YOU OR DID YOU EVER SMOKE: ☐ YES / ☐ NO IF YES, HOW MANY PACKS PER DAY? _____ NO. OF YEARS: _____
ARE YOU EXPOSED TO SOMEONE ELSE'S SMOKING AT HOME OR AT WORK ON REGULAR BASIS ☐ YES / ☐ NO

DO YOU HAVE ANY DISEASE(S) THAT RUN IN YOUR FAMILY?

☐ PROSTATE CANCER ☐ TESTICULAR CANCER ☐ KIDNEY CANCER ☐ OTHER:_____

FAMILY HISTORY (PLEASE LIST PRESENT STATE OF HEALTH OR CAUSE OF DEATH):

FATHER	ALIVE?	HEALTH	CAUSE OF DEATH	
MOTHER	ALIVE?	HEALTH	CAUSE OF DEATH	
BROTHERS	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
SISTERS	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
CHILDREN	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
SPOUSE	ALIVE?	HEALTH	CAUSE OF DEATH	

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CONSENT FOR SURGERY (Vasectomy Reversal)

(page 1 of 2)

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.

CONSENT FOR SURGERY (Vasectomy Reversal)

(page 2 of 2)

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_____

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Pre-Op Instructions

Do not take any Aspirin for at least a week before your procedure.

If you are on a blood thinner medications other than Aspirin, please call us for advice and or contact you primary care doctor.

If your vasectomy required general anesthesia, notify our office with explanation of its necessity

If you normally take any other medication daily you may take them as needed.

Please gently **shave the scrotum** on night before surgery if possible.

Take a **shower** with antibacterial soap a few hours or the night before surgery with gentle cleaning of scrotal area.

Dos and Don'ts

For your personal safety and comfort, we ask that you follow these guidelines...

1. **DO NOT eat or drink anything**, not even water, for **six hours** before your surgery even though surgery will be under local anesthesia.

2. DO NOT wear jewelry or bring valuables with you. We have no place for safe-keeping of these items.

3. DO NOT discontinue any medications unless so directed.

4. DO notify your surgeon if you are a **diabetic**.

5. DO notify if you experience any health changes between your last communication and the day of surgery -such as a cold, fever, the flu or other symptoms.

6. DO wear casual, comfortable, loose fitting clothing.

7. **DO feel free to bring DVD, or personal small audio/video device with earphones.**

8. DO arrange for someone responsible to drive you home and stay with you upon discharge. You may feel a little weak or sleepy; this is normal. Printed post-operative instructions will be given to you when you leave. No patient will be discharged after anesthesia without a responsible adult present.

Where to report

Please report at Oak Brook Medical & Surgical Center, 2425 West 22nd Street, Suite 101, Oak Brook, IL 60523 (Phone 630-990-2212) one hour before surgery time. If you have any difficulty locating the facility or any other last minute questions please call at 630-990-4244 to speak with our office or 24/7 answering service.

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Post-Op Instructions

ACTIVITY:
Your physical activity is to be restricted immediately following your vasectomy reversal. This is particularly true during the first five days after surgery. During that time you should remain relatively inactive and avoid lifting any heavy objects (anything greater than ten pounds). You should remain in bed or sit in chair for the first 24-48 hours and applying an ice pack wrapped with a terry cloth towel directly to the scrotum. This ice pack should be applied off and on for approximately forty-eight hours. You should limit stair climbing and avoid driving and limit any car rides. It is advised that you do not engage in sexual intercourse, and do not ejaculate for at least three weeks following surgery. The vas deferens must be kept "at rest".

If your job is sedentary you may resume work 5-7 days after surgery. If your job involves walking or lifting weighs you may request restricted activity for 2-3 weeks. As a general guide, follow the saying “if it hurts, don’t do it”.

DIET:

You may return to your normal diet immediately. I would suggest you eat fresh fruits and vegetables, i.e. roughage, to avoid constipation.

WOUND CARE: What to Expect and what to do.

As mentioned above, an ice pack should be applied to the scrotum off and on for the first forty-eight hours following surgery. You will go home with a jock strap, as well as gauze fluffs protecting the scrotum and incision sites. This gauze should be changed on a daily basis for at least three or four days. Please wear the jock strap for 7-10 days or longer till you are pain free. It will give you additional support and protection. Mild bleeding from wound and separation of edges is expected. If a stitch becomes loose, please do not pull it. Instead cut it at the surface of skin with a clean scissors. Please note that mild swelling, bruising and discoloration of skin (scrotum/penis) are expected and will generally resolve spontaneously in 10-14 days. You may also (sometimes) feel a small “quarter size” lump inside the scrotum underneath the incision that may take a few weeks to resolve. You are advised not to have shower for 48 hours following surgery and no tub baths till the stitches are absorbed. After quick showers, dry the area and apply over the counter antibiotic ointments (e.g., Neosporin)

MEDICATIONS:
You will be discharged with a narcotic analgesic. If the pain is not too bad you are encouraged to simply take Tylenol (acetaminophen) or Advil (ibuprofen). You will also be discharged with a 5- 10 days supply of antibiotics which you should take according to the directions on the bottle.

PROBLEMS YOU SHOULD REPORT TO US:
A: Fevers over 100.5 degrees Fahrenheit.
B: Excessive swelling of the scrotum and/or bleeding.
C: Drug reactions (hives, skin rash, nausea or vomiting).

FOLLOW-UP:
You may not need a follow-up appointment unless there are any complications or concerns. I would appreciate you calling our office within 24-48 hours on you progress. One of our nurses may do the same.

SEMEN ANALYSIS:
Since it takes nearly seventy days for new sperm to develop, we usually do not perform the first post-operative semen analysis (sperm count) until ten to twelve weeks following surgery. You will be given an order for the lab test to have semen analysis which you can arrange at a local hospital. Please call the hospital before scheduling the semen test to make sure that a cytologist is available to examine the specimen which should be done within one hour of specimen production. Please abstain from ejaculation for three days before the test. Please advise the lab to fax results to our office. Dr. Agha will call you a few days after the receipt of the test results to discuss the report.

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Vasectomy Reversal Information

The vas deferens is the tube (duct) that carries sperm from the testicle to the prostate. Vasectomy is a leading cause of obstruction of the male reproductive ducts, but many men may be born with or acquire such obstructions later in life from trauma or infection.

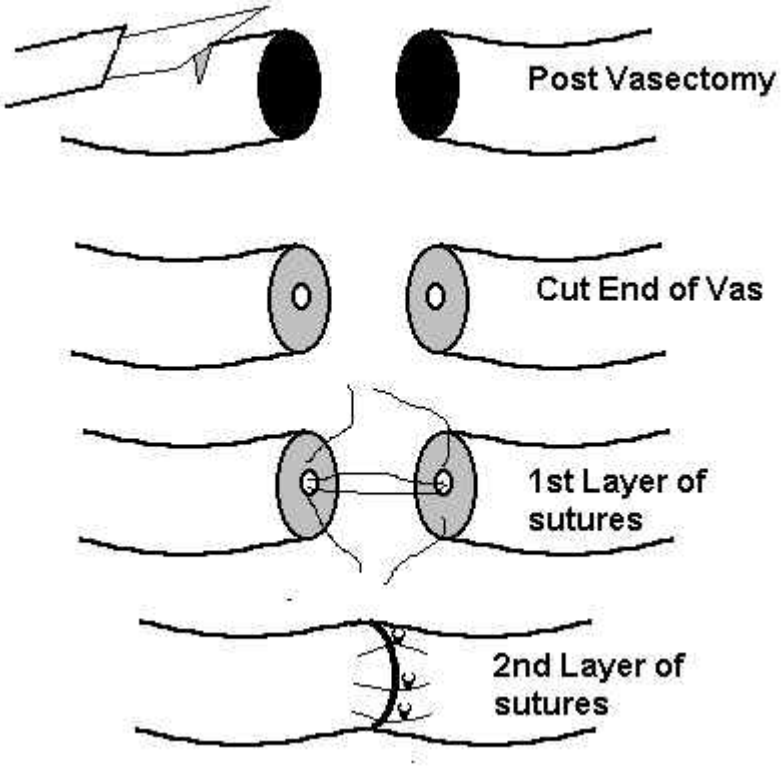
The ultimate success of a reconstructive procedure is pregnancy and is dependent on several factors: the age and fertility of the female partner, the age and previous fertility of the male, the method of vasectomy, the surgeon's experience, the technique of vasectomy reversal (the use of optimal magnification/microscope), the quality of the fluid seen coming from the vas at the time of the operations, and most importantly, the length of time since the vasectomy was performed. In a large study of 1500 patients from multiple institutions, the success rate correlated with the length of time since vasectomy. The shorter the interval from vasectomy to reversal, the higher the success rate. In men whose obstructed interval was less than 3 years, the likelihood of sperm present in the semen after reversal is as high as 95% and pregnancy was observed in 75% of the wives. On the contrary, when the obstructed interval was greater than 15 years, only 70% of men will have sperm in their semen following reversal and the pregnancy rate was significantly lower at 30%. In most men, i.e. those with obstructed intervals between 4-14 years, the likelihood of having sperm in the semen is about 80% with a pregnancy rate of 45-60%. In interpreting this data, one should keep in mind that the age of the wives plays an important role in the overall pregnancy rate. Men who are older, i.e. those who have had long obstructed intervals, may have older partners. This difference may account for some of the pregnancy rate difference as outlined above.

It is important to realize that the longer the interval of vasectomy, the more likely that a more complex reconstruction may be necessary this operation is call **Vasoepididymosostomy** (**VE**). At the time of the surgery, it may be determined that this procedure will indeed be necessary based on the quality of the fluid obtained from the vas deferens tube. This procedure connects the vas to the very small tubes of the epididymis. The epididymis is a structure situated behind the testicle which contains very small caliber tubes which is the first part of the male reproductive duct system. The success rate for epididymovasostomy is lower than for the standard vasectomy reversal (**vasovasostomy or VV**). Overall success rate for this procedure is about 40-60% that sperm will be present in the semen and 25-40% change in terms of pregnancy.

Vasovasostomy:

Vasovasostomy is done on outpatient basis under Local Anesthesia with mild tranquilizers. Oral pain medication will be prescribed and is generally required for 24-48 hours. Tylenol or Motrin may then be used. An ice pack should be placed on the scrotum for the first 24 hours. No heavy lifting, sports, or sexual activity should be engaged for 3-4 weeks. You may return to work in 7 days unless your job is physically demanding; then you may return in 10-14 days. A semen analysis will be obtained 10-12 weeks after surgery. Some men may not have sperm for 6 months to a year. If the more complex epididymovasostomy is performed, repeat semen analysis may be required for up to 18 months.

Vasovasostomy



The average length of time to achieve pregnancy is about one year. Up to 10% of patients will develop a recurrent obstruction after sperm were initially present. I recommend that you consider sperm banking once the sperm count has peaked to safeguard against this occurrence. Bleeding and infection are uncommon complications. Scarring and persistent pain at the operative site occurs very rarely.

Vasoepididymososostomy (VE)

Occlusion of the male reproductive duct is noted in 10-20% of all infertile men. It is a very important cause because it is surgically treatable. The causes of ductal obstruction include congenital absence or narrowing of the duct, scarring following infection, and vasectomy. The hallmarks of men with obstruction include azoospermia (no sperm in the ejaculate), normal testicular size and normal hormone levels. The diagnosis of obstruction can be made if, in addition to the above characteristics, the volume of the ejaculate is normal and adequate sperm production is present on testis biopsy.

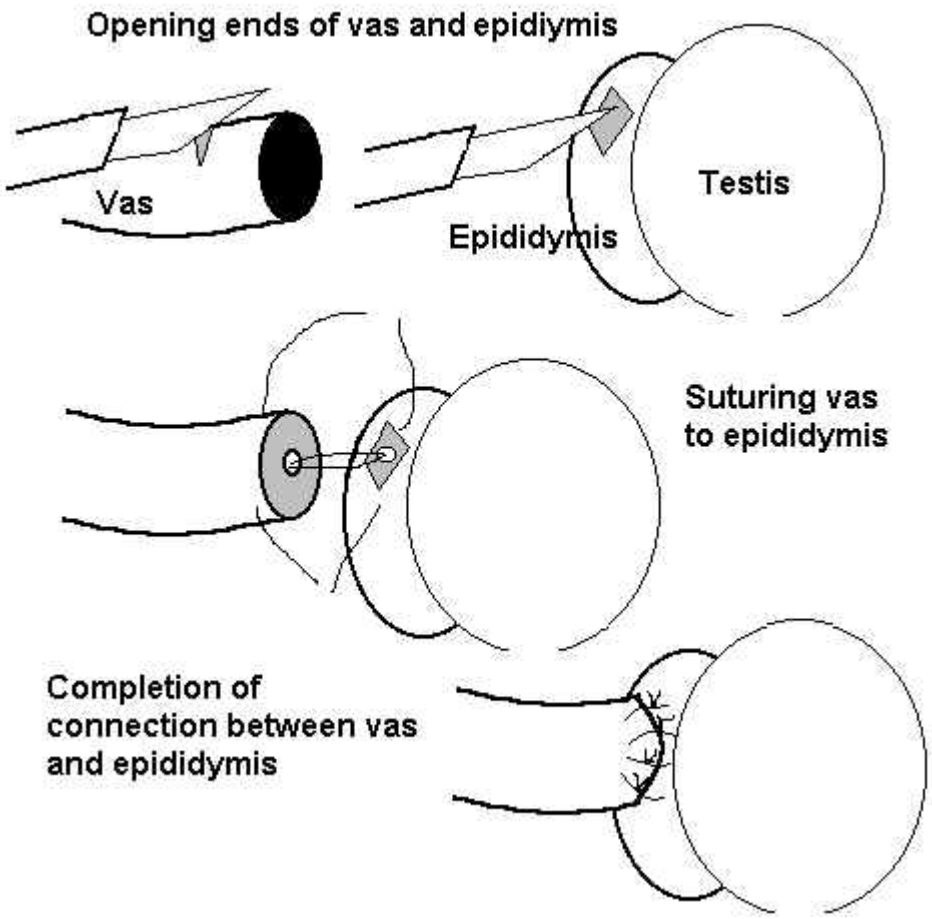
The epididymis is the structure on the back of the testicle which contains the very small tubes through which the sperm migrate and mature in. The operative procedure to correct an epididymal obstruction is called epididymovasostomy. In this procedure the vas deferens is attached to the epididymal tubule in order to bypass the obstruction in between.

The finding of sperm within the epididymal tubule is the best predictor of success. In fact, if high quality sperm are encountered in the epididymal fluid at the time of the operation, we recommend sperm banking of this sample. This is done as an insurance policy in case the procedure is unsuccessful. This sperm can then be used for IVF with intracytoplasmic sperm injection (IVF/ICSI). The overall success rate for epididymovasostomy is about 40-60% that sperm will be present following the operation, and 25-40% chance of pregnancy. Some men

may not have sperm present for up to 18 months. Pregnancy may take one to two years to achieve. There is also a 10% chance that a recurrent obstruction will develop after sperm were initially seen. Again, I recommend sperm banking as a safeguard against this problem.

The procedure is done on an outpatient basis and will take 4-5 hours. An operating microscope is required in order to visualize the very fine epididymal tubules. Anesthesia will be either general or local. A prescription for oral pain medication will be written and may be required for up to 48 hours. An ice pack should be placed on the scrotum for the first 24 hours. No heavy lifting, sports, or sexual activity should be engaged for four weeks. You may return to work in 7 days unless your job is physically demanding; then you may return in 14-21 days. A semen analysis will be obtained 8-12 weeks after surgery.

Vasoepididymosostomy



You should also consider the option of sperm harvest at the time of this procedure. In men whose procedures were unsuccessful, the need for sperm remains. We can either collect sperm from the epididymal fluid or remove a small portion of the testis and extract sperm for storage. This sperm can then be used for IVF or be substituted later with better quality ejaculated sperm. The advantage of ejaculated sperm is that if they are of sufficient quality and quantity, they may be used for the much simpler insemination rather than IVF

SPERM ASPIRATION/EXTRACTION

Recent breakthrough in IVF enables us to achieve pregnancy with a very small number of sperm. In men with production problems or obstruction not amenable to surgical reconstruction, directly obtaining sperm from the testicle or epididymis for IVF is the only option for biological parenthood.

Testicular and epididymal sperm are functionally immature. They are not very motile and most do not have the ability to home in on the eggs, even if they are placed together in a test tube. They must be directly injected into the eggs to achieve fertilization through a procedure called IVF/ICSI.

Testicular and epididymal sperm cannot be used for intrauterine insemination due to their functional immaturity and the low number of such sperm retrievable. Their use requires IVF/ICSI.

The sperm may be sucked out with a small needle (aspiration) or processed out from a small piece of testis tissue (extraction). Aspiration can only be used in men with normal sperm production; it is less traumatic but removes only a very small number of sperm, too few for sperm banking, but sufficient for immediate use. Sperm aspiration/extraction with IVF/ICSI is and alternative to surgical reconstruction. There are pros and cons for each approach; in my opinion, vasectomy reversal is more appropriate for most men, if one considers the likelihood of success and overall costs.

We strongly recommend that you become well-informed of all aspects of these options before reaching a decision. We are here to help you, and we look forward to the opportunity to discuss with you the various options available and answer any questions you may have.

Please fill out and sign where needed from Page 1 through 4 (of 10) of this package and mail along with payment.