# DISCLOSURE AND CONSENT FOR ORCHIECTOMY (REMOVAL OF TESTIS)

**TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.**

**Description of Medical Care and Surgical Procedure(s)**
I voluntarily request my physician/health care provider _____and other health care providers, to treat my condition which is:

_____
(Diagnosis)

I understand that the following care/procedure(s) are planned for me (patient/other legally responsible person **initial**):

_____ Orchiectomy (Removal of the Testis(es))

**Potential for Additional Necessary Care/Procedure(s)**

I understand that during my care/procedure(s) my physician/health care provider may discover other conditions which require additional or different care/procedure(s) than originally planned.

I authorize my physicians/health care providers to use their professional judgment to perform the additional or different care/procedure(s) they believe are needed.

**Use of Blood -** Please initial "Yes" or "No":

_____ Yes ____ No I consent to the use of blood and blood products as necessary for my health during the care/procedure(s). The risks that may occur with the use of blood and blood products are:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys, and immune system.
3. Severe allergic reaction, potentially fatal.

**Photographing or Videotaping -** Please initial "Yes" or "No":

____ Yes ____ No I consent to the photographing or videotaping of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing my identity is not revealed by descriptive texts accompanying the pictures.

**Manufacturer's Technical Representatives -** Please initial "Yes" or "No":

____ Yes ____ No I consent to have one or more manufacturer's technical representatives, as requested by my physician in the room during the procedure. I understand that one or more representatives from the equipment and/or Supply Company for the products the physician will use during my procedure, may be present for the procedure but will not perform any portion of the procedure. I further understand that all manufacturer's technical representatives present have confidentiality agreements and that none of my personal health information will be disclosed to anyone other than my caregivers with the hospital.

____ Yes ____ No I consent to the disposal by hospital authorities of any tissue or parts which may be removed.



PATIENT IDENTIFICATION

# DISCLOSURE AND CONSENT FOR ORCHIECTOMY (REMOVAL OF TESTIS)

**Risks Related to this Care/Procedure(s)**

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedure(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death.

The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's current health.

Risks of this care/procedure(s) include, but are not limited to **[include additional risks if any]:**

- Reduced sexual desire
- Difficulties of penile erection
- Permanent sterility (inability to father children) if both testes are removed
- _____
- _____

**Granting of Consent for this Care/Procedure(s)**

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
  1. Alternative forms of treatment,
  2. Risks of non-treatment,
  3. Steps that will occur during my care/procedure(s), and
  4. Risks and hazards involved in the care/procedure(s).
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

**Patient/Other Legally Authorized Representative (signature required):**

_____ _____

Print Name Signature

**If Legally Authorized Representative, list relationship to Patient:** _____

Date: _____ Time: _____ AM/PM



PATIENT IDENTIFICATION

# DISCLOSURE AND CONSENT FOR ORCHIECTOMY (REMOVAL OF TESTIS)

**Witness:**

Print Name _____ Signature _____

Address (Street or P.O. Box) _____

City, State, Zip Code _____

**Second Witness if Telephone Consent:**

**Print Name** _____ **Signature** _____

**Language Services Used** ☐ **Yes** ☐ **No** **Language Provider Confirmation Number:** _____

**Physician Attestation**
I have explained the Risks, Hazards and Benefits involved in the medical care, technical and/or surgical procedure(s) outlined on this consent form to the patient or the person authorized to give informed consent prior to their consent. If written materials explaining the Risks/Hazards/Benefits are required to be provided to the patient by the provider performing the medical care and/or surgical procedure, those have been provided.

Physician Signature: _____ Date: _____ Time:_____AM/PM_____

Consent and Disclosure Form Adopted from the Texas Administrative Code Figure: 25 TAC §601.4(a)(1).