GEORGIA LITHOTRIPSY & LASER CENTER, INC. INFORMED CONSENT CIRCUMCISION

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

The following has been explained to me in general terms and I understand that:

- 1) The nature of the procedure is the removal of the foreskin of the penis.
- 2) The purpose of this procedure is to remove the skin for cosmetic, hygiene or medical indications as described above.
- 3) MATERIAL RISKS OF THIS PROCEDURE: As a result of this procedure being performed, there may be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.
- 4) In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:
 - a. meatal stenosis (narrowing of the urethral opening);
 - b. severe, life threatening infection;
 - c. formation of a hematoma (blood clot) in the penis;
 - d. scar tissue between the penis and glans (head of penis);
 - e. Urethrocutaneous fistula;
 - f. Injury to urethra;
 - g. injury to penis;
 - h. curvature of penis with erection;
 - i. removal of too little or too much skin, possibly necessitating another operation;

If I choose not to have the above procedure, my prognosis (future medical condition) is:

j. pain in the penis;

5)	The likelihood of success of the above procedure(s) is:			
	() Good () Fair () Poor			
6)	Practical alternatives to this procedure include: doing nothing			

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary or appropriate to perform additional procedures which are unforeseen (not known to be needed) at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

7)

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedure described herein.

I also consent that any tissues (biopsies), specimens, organs or limbs removed from the patient's body in the course of the procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAVE HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

described or re	ne information above and I ferred to herein by Drnnel who may be involved in the second control of the		he performance of the procedure any other physicians or other	
Witness		Person giving consent	Date/Time	
Date	Time	Person giving consent (Print Name)		
		Relationship to patient if not the	Relationship to patient if not the patient:	
		Patient unable to sign because		