ANNE ARUNDEL UROLOGY, P.A.
Anne Arundel Urological Surgery Center, L.L.C.

Annapolis Office 410-266-8049 **Glen Burnie Office 410-768-0036**

V A S E C T O M Y

►Pre Procedure Instructions

1. You may have a light meal 1 - 2 hours before the procedure.
2. **Discontinue the following medications as directed:**
   Aspirin 10 days prior
   Plavix 7 days prior
   Coumadin 5 days prior
   All Anti Inflammatory medications, all over the counter medications, all vitamins, all supplements and all herbal remedies must be discontinued 7 days prior to the procedure.
3. You may take **TYLENOL ONLY** for pain relief the week prior to the procedure.
4. Shave the FRONT of the scrotum the morning of your procedure.
5. Shower with soap and water the night before and again after shaving on the day of the procedure.
6. Bring an **Athletic Supporter** to the procedure with you.
7. Review and sign the **CONSENT** form prior to the procedure. Your spouse needs to sign as the witness to your signature. Bring the completed consent form with you the day of your procedure.
8. Review and sign the **DISCHARGE INSTRUCTIONS** below. Bring this form with you also.
9. **You MUST have someone drive you to and from the procedure.**
10. A staff member from the Surgery Center will call you prior to the procedure to review your Medical and Surgical History and the Medications you are currently taking.

►Post Procedure & Discharge Instructions

1. Apply **ICE PACKS** to the scrotum 10 minutes of each hour while awake for the first 24 hours after surgery (a bag of frozen peas or corn work nicely). Make sure that the ice packs are not placed on bare skin.
2. **Bed rest** for 24 hours, except to go to the bathroom.
3. You may **shower after 24 hours**.
4. You may perform usual activities after 24 hours as tolerated, but **no heavy work or lifting more than 20 lbs. for 1 week.**
5. Starting after 48 hours, you may sit in a tub of warm water twice daily for additional comfort, if needed. Keep the water warm and soak for 10-15 minutes. Do not sit in the tub if you still have bleeding from your incision.
6. **Wear the supporter for at least 3-4 days** and thereafter for as long as it gives you comfort. Change the dressing using 4 x 4 gauze (available in any drug store) as necessary.
7. Your may resume **sexual relations after 72 hours**, but **CONTINUE EFFECTIVE CONTRACEPTION** until it has been proven that your semen specimen contains no sperm. The surgery does NOT provide immediate sterility.
8. Some bruising(black and blue), draining (oozing) from the incision, swelling or mild tenderness of the scrotum are not unusual. The edges of the incision may pull apart slightly and heal rather slowly. There may be a knot present which remains for several months. **These are all part of the normal healing process and are nothing to worry about.**
9. Approximately 8 – 10 weeks after your vasectomy, drop off a specimen at either office: Annapolis or Glen Burnie. Bring the specimen in a small, clean, wide mouth container **(NOT A CONDOM)** within 1-2 hours of collection. The specimen must be accepted by a staff member. Please make sure that you have labeled the container with your name and date of birth. Hours for accepting specimens are as follows:
   ANNAPOLIS Office , Suite 130 - **Monday thru Friday 9am to 3pm.**
   GLEN BURNIE Office , Suite 503 - **Call ext . 200 for specific drop off times.**
10. Call the office immediately if you have any of the following:
    FEVER > 101◦ and / or CHILLS
    NAUSEA and / or VOMITING
    EXCESSIVE SWELLING
    FOUL SMELLING and / or PURULENT DISCHARGE
    PAIN NOT RELIEVED BY PAIN MEDICATION
11. You may take over the counter Tylenol or pain medication (if prescribed) for pain relief.
    DO NOT TAKE ANY ANTI-INFLAMMATORY MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS or SUPPLEMENTS FOR 1 WEEK AFTER THE PROCEDURE.
12. A member of our staff will call you the day after the procedure to follow up with you.

My signature below confirms I have received and reviewed the above instructions:

____________________ __________ ____________________

Patient Signature Date Witness Signature

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INFORMED CONSENT for SURGICAL PROCEDURE

1. Consent: Dr. Herzinger, Biles, Zagula, Danneberger, McDermott, Roland, Rock, Schwartz or Associate has recommended the procedure/surgery checked below. **I consent to the procedure/surgery to be performed by the surgeon as authorized by my initials:**

2.

Patient Initials:	Procedure / Surgery:	Patient Initials:	Surgeon:
______________	☐ Vasectomy	______________	☐ Dr. Herzinger
______________	☐ Cystoscopy	______________	☐ Dr. Biles
______________	☐ Transrectal Ultrasound	______________	☐ Dr. Zagula
______________	☐ Transrectal Ultrasound & Prostate Needle Biopsy	______________	☐ Dr. Danneberger
		______________	☐ Dr. McDermott
______________	☐ Stent Removal	______________	☐ Dr. Roland
______________	☐ Circumcision	______________	☐ Dr. Rock
______________	☐ Bladder Biopsy	______________	☐ Dr. Schwartz
______________	☐ Excision of Genital Lesions	______________	☐ Associate: ___________________
______________	☐ Other: ______________ ____________________		

3. I consent to the administration of anesthesia if required and to the use of such anesthetics and techniques as may be deemed advisable. I understand that the anesthetic will be administered by a person qualified in the administration of the appropriate anesthetic.

4. No Guarantee: No guarantee has been made to me about the outcome of the procedure/surgery. I understand that it sometimes is not successful.

5. Method, Alternatives and Risks: The details of the operation / procedure, alternatives, including the opportunity to decline, and the possible complications and other risks involved (listed below) have been explained to me by my practitioner. Any questions that I have concerning the above procedure have been answered to my satisfaction.

6. **Risks - All Procedures Listed Below: INFECTION (fever or chills), BLEEDING (from procedure specific area), PAIN**

Additional Procedure Specific Risks:

☐ **PROSTATE BIOPSY**
Urinary Retention
Catheter
Injury to tissue
Inconclusive biopsy results
Blood in Semen

☐ **VASECTOMY**
Bleeding
Failure of surgery
Injury to tissue
Inconclusive Assoc. with Prostate Cancer

☐ **CIRCUMCISION**
Swelling

☐ **CYSTOSCOPY / CMG / DILATION**
Urinary retention
Injury to tissue
Catheter
Irritative Bladder Symptoms

☐ **EXCISION & DRAINAGE / EXCISION OF GENITAL LESIONS**
Foul smelling drainage, redness, tenderness

☐ **OTHER:** ____

7. Complications and unforeseen conditions: Risks may include; unexpected bleeding, and other emergency situations which would necessitate the transfer to Anne Arundel Medical Center or North Arundel Hospital, which may involve a blood transfusion. Risks associated with blood transfusions include, but are not limited to, transfusion reaction, hepatitis and AIDS (Acquired Immune Deficiency Syndrome).

8. Tissue: I consent to the study, use and disposal by the physician of any tissue or part, which may be necessary to remove.

9. **ADVANCE DIRECTIVE directions will be suspended while undergoing procedures in AAUSC.**

10. Special Remarks: ____
____

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE WITH WHAT IT SAYS.

______________________________	__________	______________________________	__________
Signature of Witness	**Date**	**Patient's Signature**	**Date**
______________________________	__________	______________________________	
Signature of Legal Guardian / Parent	**Date**	**Signature of Physician**	

Revised 3/05 Jpoole,RN