NORTH FLORIDA OB GYN LLC

CIRCUMCISION CONSENT FORM

PROCEDURE – CIRCUMSICION

Removal of a portion of the foreskin from the penis, with or without the use of a local anesthetic.

PURPOSE OF THE PROCEDURE

To remove a portion of the foreskin for cosmetic, hygienic or cultural reasons.

POSSIBLE ALTERNATIVES

Do nothing.

RISKS OF THE PROCEDURE:
Bleeding, infection, pain, allergic reaction to medication that may be used for numbing the penis or latex. Possible scarring, injury to the penis or urethra or repetition of the procedure if not enough of the foreskin is initially removed.

RISKS IF PROCEDURE IS NOT DONE:
None unless the procedure is medically indicated.

My child's condition, these procedures, alternative treatments (including no treatment) and the risks of these procedures have been explained to me. I have had an opportunity to ask questions and I understand the information provided.

I understand that any tissue removed will be sent for further evaluation as appropriate and it is my responsibility to make sure I am given those results. I also agree to follow any pre and post procedure instructions given to me and to contact the office if I have any problems.

I _____ consent to allow _____ to perform the procedures described above and any additional procedures that they find necessary at the time unless I refuse such procedures at that time.

_____ _____
(Signature of patient or legal guardian) (Date)

_____ _____
(Signature of witness) (Date)

<u>Please sign below if you do not wish to have a circumcision performed on your child:</u>

After careful consideration of the risks and benefits of this procedure as well as the risks of not having it done, **I do not** wish to have my child circumcised. I take full responsibility for the consequences of not having the procedure done.

_____ _____
(Signature of patient or legal guardian) (Date)

_____ _____
(Signature of witness) (Date)

Mother Mother's DOB: