Blue Ridge Pediatric & Adolescent Medicine, Inc.

Circumcision Consent Form

Patient's Name: _____ Patient's DOB: _____

This consent process should be considered an important conversation between you and your health care provider. This consent form conveys to you the risks, benefits, alternatives and possible complications that could occur with this procedure. By reviewing this form you will learn what you can expect from receiving this procedure. By signing this form you are attesting that all your questions have been answered to your satisfaction by your health care provider and that you are giving consent to proceed with the procedure.

By signing this consent, I understand that circumcision is an elective procedure that involves the removal of the normal male foreskin. I understand that my child will be placed in a standard circumcision immobilization device, local anesthesia will be administered and the foreskin removed by using the appropriate clamp or plastibell ring.

I understand that there is a chance for risk and complication associated with this procedure. These risks and complications include but are not limited to bleeding or infection at the site, fever and possible decreased flow of urine. I understand that if my child does not urinate normally within six to eight hours after the procedure, I need to contact my pediatrician at (828) 262-0100. If a plastibell ring is used, I understand that it can take up to 14 days from the procedure for it to fall off.

I understand that if such complications occur, my child may need to undergo additional medical procedures which are not known to be needed at this time.

_____, MD will perform the procedure. The above risks have been explained to me and I have had the opportunity to fully inquire about the risks and benefits of circumcisions and its alternatives. I hereby provide my informed consent to perform this procedure and any such procedures at his/her discretion if needed during the procedure. All my questions were answered to my satisfaction and I consent for my child to receive local anesthesia and treatment as described in this form.

_____ _____
Signature (Parent or Legal Guardian) Date

_____ _____
Print Name (Parent or Legal Guardian) Relationship

_____ _____
Physician Signature Date

_____ _____
Witness to Signature Date