

Male Patient Name: _____ Social Security # _____



THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY*
TESTICULAR BIOPSY
Description, Explanation and Informed Consent

I, _____; consent to the performance of the following procedure(s) to be performed by Dr. _____ at **The Center for Human Reproduction**.

- **Retrograde Ejaculation Sperm Collection:** I have been treated with a medication to alkalinize my urine to facilitate sperm viability. I understand that my bladder will be catheterized, drained, and rinsed with a sperm processing media. I also understand that the catheter will be placed after I have ejaculated to collect the retrograde specimen. This specimen will be processed to facilitate isolation of viable sperm.

I understand that there are risks associated with these procedures. These include but are not limited to: urinary infection, lower urinary tract symptoms, pain, bleeding, fever, chills, urethral stricture and urinary retention.

Dr. _____ has explained the procedure to me and informed me of the risks involved in this procedure, the risks involved if I do not undergo this procedure, the possible alternative methods of treatment, and of the risks involved in these alternative methods. I have had an opportunity to discuss this procedure(s) with Dr. _____ and/or his staff and have received answers to all questions I have asked. The possible outcomes of this procedure have been explained to me, and I understand there is **NO GUARANTEE** that any particular results will be obtained.

Dr. _____, the attending physician will perform or supervise the performance of this procedure. I authorize the physician performing this procedure to obtain the assistance of other physician(s), including residents and interns; as he considers advisable. In addition, I authorize the physician performing this procedure or an assisting physician or staff designated by **The Center of Human Reproduction** to administer anesthesia to me as required during the course of the procedure with the exception of: _____

The Center for Human Reproduction is a teaching facility, medical education and research is part of the facility's role. For the purpose of advancing medical education, I consent to the observation of this procedure(s) by qualified observers (including medical and nursing students). I also authorize **CHR** and its agents to publish the pictures in scientific journals and exhibit them for educational purposes, providing that the information of my identity is not revealed. (If the patient's identity would be revealed by publication of the pictures or accompanying text, they will not be published unless I specifically agree to this in writing).

I do hereby consent to pay any charges incurred related to this procedure. It is my understanding that there is a direct charge for the procedure itself and that there may be a separate sedation charge, consultation fee and/or laboratory charges. In the occurrence that the insurance carrier denies my eligibility or coverage for these services, I will be fully responsible for remittance of all fees. I have read and fully understand this consent to diagnostic procedure. All the blank spaces were filled in before I signed this form. I have read and understand the foregoing information. I have discussed this with my physician(s) and my spouse, (if applicable).

Date

Signature of Patient

Patient Name-Print

As one of the staff members of The Center for Human Reproduction by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date

Signature of Witness

Witness Name-Print

* Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)
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04/24/2001