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 Physician at **The Center for Human Reproduction.**

- **Testicular biopsy(s)-**a small scrotal incision is made and carried down to the tunica albuguinea (covering of the testicle). Then a small incision(s) is made in the testicle and testicular tissue is extruded and incised. This tissue will be processed and inspected for the presence of sperm. The testicular tissue from this approach will be sent to a pathologist for formal evaluation as a testicular biopsy specimen(s). Some of the testicular tissue may be frozen for future use to be used in coordination with fertility treatment.

I understand that there are risks associated with these procedures. **These include but are not limited to:** fever, chills, infection, bleeding, hematoma, pain, testicular injury, testicular atrophy, and loss of testicular size and/or function. There are also risks associated with the use of local anesthesia as well as intravenous sedation.

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)