

**THE REED CENTRE**  
**for Ambulatory Urological Surgery**

1111 KANE CONCOURSE  
BAY HARBOR ISLANDS, FLORIDA 33154  
Phone (305) 865-2000 / Fax (305) 865-2002

**INFORMED CONSENT FOR BILATERAL ORCHIECTOMY**

1. I hereby request and authorize Dr. Harold M. Reed, and his designated urological associated and surgical technicians, to perform the urological operation entitled "Bilateral Orchiectomy" (or removal of the testicles and cord).
2. I have given careful consideration to the implications of this type of operation as far as the irreversible result and the change of my life style both mentally and physically. I have had an opportunity to consider sperm banking.
3. The intended area of the incision in the scrotal area has been shown to me, as well as a description of the procedure with reference to my personal anatomy.
4. I will abstain from sexual activity for 2 weeks following surgery.
5. Surgical risks include bleeding, hematoma, infection, incisional separation, tissue injury, post-operative pain, allergic reaction and the remote possibility of thromboses and embolism (blood clots), and cardio-pulmonary events.
6. I have received 2 letters of therapy clearance (psychologist, psychiatrist, social worker, sexologist), one from a therapist with a doctoral degree and one from a therapist who has known me for an extended period of time (one therapist can satisfy both of these requirements).
7. The administration of general anesthesia, should an anesthetist or anesthesiologist be used, is an independent function and any questions regarding anesthetic management should be addressed directly to the anesthetist. A remote complication of general anesthesia is inadequate intubation, and a remote complication of spinal anesthesia is inadequate pain control.
8. I have had ample opportunity to discuss the intended procedure with Dr. Reed and he has answered any questions that I might have.

I have read and signed the above consent in the presence of a witness whose signature appears below, after I have had an opportunity to question Dr. Reed regarding any unfamiliar medical terminology.

Dr. Reed has a proprietary interest in this CENTRE. You may wish to consider alternative sites for evaluation and treatment.

Pursuant to statute 64B8-9.0091, (FAC), this surgical facility is not operating as an ambulatory surgical centre (ASC) for the purposes of this consent.

DATE:\_\_\_\_\_TIME:\_\_\_\_\_

PATIENT NAME:\_\_\_\_\_

WITNESS:\_\_\_\_\_

I have personally discussed with the patient the above operation, its risks and potential complications, as well as alternatives available.

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HAROLD M. REED, M.D. P.A.  
(conorchiectomy)