THE REED CENTRE
for Ambulatory Urological Surgery

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

CORRECTION OF PEYRONIES WITH INSERTION OF "TUTOPLAST" CADAVERIC PERICARDIAL GRAFT

A revision procedure has a higher incidence of complication than the original procedure

1) I give consent to Dr. Reed and his elected assistants to perform the above operation for Penile Angulation, after learning about all the alternatives in management in such a situation, with the pros and cons and risks mentioned.

2) I understand the technique Dr. Reed will employ is to deglove penile skin, lifting the neuro-vascular bundle and/or separating the urethra from the erectile bodies as needed, release of scar tissue, and overlay of a Tutoplast cadaveric pericardial graft to the defect, and possibly suture plicating the contralateral side if full correction is not deemed adequate. An artificial erection which will be produced either by injecting normal saline into the corpora via a butterfly needle or by injecting into the corpora vaso-dilating agents. Transient or permanent numbness may result. No promise has been made that a specific result or perfect correction of the angulation will occur following surgery.

3) I will not use my penis sexually for at least 8 weeks.

4) I recognize the complications that could occur include stitch reaction, infection, hematoma, seroma, loss of sensation, vascular injury, erectile impairment, swelling, loss of penile length, loss of penile tissue and/or skin, prolonged pain, under-correction or over-correction of curvature, and the remote possibility of a cardio-pulmonary event.

5) I understand the maintenance of personal hygiene, especially genital cleanliness is extremely important in preventing post-operative infection and promise to follow discharge instructions carefully.

6) I have had an opportunity to discuss the informed consent contained herein with Dr. Reed, and question him about any unfamiliar medical terminology.

7) I recognize the performance of general anesthesia is an independent function. If the patient elects for a spinal type anesthetic, regional or epidural, a complication that could occur includes inadequate pain control. If the patient receives a general anesthetic a remote complication includes inadequate intubation.

8) The information presented above by Dr. Reed although intended to be comprehensive

and detailed, is not purported to cover every conceivable aspect of surgery, post operative recovery, or complications.

9) I recognize that there are inherent risks in all surgical procedures and can appreciate the possibility of side effects and complications stemming both from the procedure and recovery there from.

10) I have had ample opportunity to discuss the intended procedure with Dr. Reed and he has answered any questions that I might have.

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

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.

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

_____day of _____________________, 20_____
in the presence of witness whose signature appears below.

____
PATIENT

____
WITNESS

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

____
HAROLD M. REED, M.D.