Space for Medical Institution Name and Logo

/יולי 1997 OUROL/DTP/IVFט 0017/

טופס הסכמה: דיקור ושאיבה של תאי זרע מאשך /או מיותרת האשך ו/או להשגתם באמצעות ניתוח באשך ו

CONSENT FORM: PUNCTURE AND ASPIRATION OF SPERM CELLS FROM TESTICLE AND/OR TESTICULAR SAC AND/OR BY TESTICULAR SURGERY

Invasive procedures for collecting sperm cells are performed when sperm cells are not present in the semen. It is possible to obtain sperm cells by puncture and direct aspiration from the testicle, or by excision of a sample from the testicular tissue.

The procedures are carried out under local or general anesthetic.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the procedure of puncture and aspiration of sperm cells from the testicle and/or testicular sac and/or excision of a fragment of testicular tissue (henceforth: "the primary procedure").
It has been explained to me that there is a possibility that in order to obtain sperm cells it may be necessary to go from one procedure to another of the abovementioned procedures, and there may be a need for more than one puncture and/or puncture/operation of both testes.
I hereby declare and confirm that it has been explained to me that the invasive methods of collecting sperm are relatively new and the rate of pregnancy from sperm collected by these methods is not high. When the problem arises from reduced production of sperm the pregnancy rate is about 15%. In cases of normal sperm production in the testicle but there is obstruction or degeneration of the sperm tubules, the pregnancy rate is about 30%.
It has also been explained to me that in about 40-50% of men who have no sperm in their semen, there will also be no sperm in the testicular tissue removed by operation. It has been explained to me that there is a possibility that men with a minimum of sperm who require the abovementioned invasive procedures may transfer the fertility problem to their sons by heredity. It has been explained to me that the sperm cells that have arisen as a result of the treatment, if they are found, will serve for the fertilization of the ova of his partner. Any remaining tissue or sperm cells will be frozen and will serve for attempts at additional fertilization if I should need them in the future.
I hereby declare that I have received an explanation of the alternative treatments and of the side effects after the primary procedure including pain, discomfort and the development of antibodies to sperm cells.

I received an explanation concerning the risks and complications of the primary procedure, including infection, hemorrhage, temporary swelling of the scrotum that may interfere with day to day activities and in rare cases degeneration of the testicle(s).
I hereby give my consent to perform the primary operation.
I hereby declare and confirm that I have received an explanation and understand the possibility that during the primary procedure the need to extend or modify the operation, or perform additional or different procedures, may arise, in order to save my life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time, but whose significance has been made

clear to me. I, therefore, also give my consent to such an extension, modification or performance of different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary procedure.
I also consent to the performance of local anesthesia at the discretion of the physicians, after the possible complications of local anesthesia have been explained to me including an allergic reaction of varying degree to the anesthetic materials. If a general anesthetic will be decided on an explanation will be provided by an anesthesiologist.

I know, confirm and agree that the primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

_____	_____	_____
Date	Time	Patient Signature

I hereby confirm that I provided the patient with a detailed verbal explanation of all the abovementioned, as required, and that he signed the consent form in my presence after I was convinced that he fully understood my explanations.

_____	_____	_____
Name of Physician	Physician's Signature	License No.