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CONSENT TO CIRCUMCISION

I, _____ , hereby consent to the circumcision on my son, _____
(Name of Patient or Substitute Decision Maker)

to be performed by Dr. Ohayon.

I acknowledge that Dr. Ohayon has explained to me the nature of the circumcision procedure, including the following:

- Reasons for circumcision: including expected medical benefits, along with family desire and ritual need.
- The sterile preparation and pain control techniques. These include oral acetaminophen and/or topical lidocaine (ie EMLA) and/or injectable/subcutaneous local anesthetic.
- The potential for all circumcision related outcomes, risks and side-effects. These include risks of pain, bleeding, delayed urination, infection and unexpected wound healing (tethering of penis, revelation of a mild glandular hypospadius post circumcision). He also discussed the possible, but extremely remote risk of cutting the tip of the glans of the penis.
- He also explained to me the alternative courses of action in the likely consequence(s) of the above complications. These include therapy for pain relief, techniques for bleeding (hemostasis) that may require either/or all of the following: pressure tourniquet bandage over penis, local cautery and/or stitching of wound, and if required, transfer to ER for further assistance in bleeding control. Antibiotics may be required for treatment of suspected infection. Finally and rarely, despite appropriate technique, there may remain the need for revision of the circumcision.
- I fully understand the information provided to me by Dr Ohayon and was offered the opportunity to ask him any questions.

I consent to the above circumcision fully aware of the benefits, risks and, if required, necessary treatment for unexpected outcome, which in the opinion of Dr Ohayon is reasonably necessary. I also consent to the administration of local anesthetics for any of these purposes as may be required.

I understand that Dr. Ohayon is a teaching health care professional and agree that other members of his medical, intern, resident or health professional staff, other than Dr. Ohayon may perform or assist in the circumcision procedure as required.

I declare that I have read this form and fully understand it.

_____ (Signature of Parent, over 18)	_____ (Signature of Substitute Decision Maker)
_____ (Printed Name of Patient)	_____ (Printed Name of Substitute Decision Maker)
_____ Date – (yyyy/mm/dd)	_____ (Relationship to Patient)

STATEMENT BY HEALTH PRACTITIONER

I declare that I have explained to _____ the nature of the treatment, the expected
(Name of Patient or Substitute Decision Maker)

benefits, material risks, material side-effects, the alternative courses of action and the likely consequences of the circumcision. I have responded to any and all questions about such matters.

_____ _____
Jason A. Ohayon M.D. FRCPC Date – (yyyy/mm/dd)