

This information is given to you so that you can make an informed decision about having **Orchiopexy surgery**.

Reason and Purpose of the Procedure:

Orchiopexy is a surgery to move a high riding testicle into the scrotum (the sac or pouch). If both testicles have not dropped, then we may possibly recommend a human chorionic gonadotropin (HCG) injection. This is a hormone therapy that may cause the testicles to drop. Orchiopexy is done as an open operation that involves small openings into the skin, or as a laparoscopic operation done through a scope with instruments that enter the body through tiny incisions.

Benefits of this surgery:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Decrease discomfort
- Decrease the risk of infertility

Risks of Surgery:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of surgery:

- Small areas of the lungs may collapse. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- Clots may form in the legs, with pain and swelling. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- A strain on the heart or a stroke may occur.
- Bleeding may occur. If bleeding is excessive, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

Risks of this surgery:

- **Chronic Pain:** You may develop chronic pain in an area that you had surgery on.
- **Hematoma:** A blood vessel may continue to ooze or bleed after the procedure is over. This can cause bruising and swelling that usually resolves over time.
- **Infection:** You may need an antibiotic or further treatment.
- **Testicular Ischemia/Loss:** A testicle may lose its blood supply from the attempt to lengthen the cord. The testicle may shrink or not survive.
- **Vas Deferens Injury:** This is the small tube that moves the sperm from the testicle to the urethra. During the operation it could be cut or damaged. It would be repaired during the surgery if possible, or may be repaired at a later date.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

Alternative Treatments:

- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment:

- You may have a higher risk of testicular cancer in your lifetime.
- You may be at risk for infertility.
- You may have continued discomfort.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

My insurance company may not pay for this procedure. I know I am responsible for charges not covered by my insurance.

Patient Name: _____

DOB: _____

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
 - I understand its contents.
 - I have had time to speak with the doctor. My questions have been answered.
 - I want to have this procedure: Right Left **Orchiopexy**
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- I understand that my doctor may ask a partner to do the surgery.
 - I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Patient**Signature** _____**Relationship** Patient Closest relative (relationship) Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

*Interpreter (if applicable)*_____
*Date*_____
*Time***For provider use only:**

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options and possibility of complications and side effects of the intended intervention. I have answered questions and patient has agreed to procedure.

Provider Signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

or

____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness: _____ Date: _____ Time: _____