GREATER LANSING

REQUEST AND CONSENT FOR CIRCUMCISION

I voluntarily request and consent to have Dr. ________________________________ as my infant's physician, and such associates, assistants and other health care providers as he/she deem necessary, to perform a circumcision on my infant.

I know that medical science is not perfect and many things are not predictable. I understand that my infant's physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my infant's physician, and his/her designees, to perform such other procedures which are advisable in their professional judgement.

This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Generalized risks include, but are not limited to: infection, bleeding, nerve injury, and severe allergic reactions.

I understand that no warranty or guarantee has been made to me as to the result.

If applicable, I consent to sedation or local anesthesia to be given by or as directed by my infant's physician.

The nature, purpose, consequences, risks and possible complications of the procedure have been explained to me.

I have been informed of and understand the alternative to the procedure listed above.

I deny known family history of hemophilia or other bleeding disorders.

My request and consent for this circumcision is the result of my discussion with the physician. I have had the opportunity to ask questions, and they have been answered to my satisfaction.

Signature of parent/legal representative ____________________________ Date ________ Time ________

Relationship to patient ____

Witness ____

Physician Affirmation

I or my physician associate have explained to the infant's parent or his/her legal representative the nature of the procedure, and the benefits to be reasonably expected. I have also discussed the possibility of risks or complications of this procedure. I have documented the above in my notes on the hospital record.

I or my physician associate have given the infant's parent/legal representative the opportunity to ask questions, and believe all questions have been answered to the parent/legal representative's satisfaction.

Signature of physician ____ Date ________ Time ________

PT.

MR.#/RM.

DR.

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PRE-CIRCUMCISION ASSESSMENT AND PROCEDURE RECORD

Pre-Circumcision Assessment

To be completed by Physician (circle response)

Yes No Infant is through transition and is stable
Yes No Vital signs are normal
Yes No There are no obvious anomalies
Yes No Infant is managing oral secretions appropriately
Yes No Infant has voided

Procedure Record

Yes No Time out done

Procedure Used:

____ Gomco: small medium large (circle one)
____ Plastibell: 1.2 cm 1.3 cm 1.5 cm (circle)
____ Morgan clamp
____ Other (describe): ____________________________

Anesthesia Record

____ Dorsal penile nerve block with 1% plain lidocaine
____ Local anesthesia with 1% plain lidocaine
____ Topical anesthesia
____ None used

Estimated Blood Loss: ______________

Circ Date: ________________________
Time Off Circ Board: _______________
Circ Supplies in Crib: _______________
Instructions Given (signature): ________________________

Nursing Assessment

Time				
Scant Bleeding				
Small Bleeding				
Mod. Bleeding				
Large Bleeding				
Swelling (yes/no)				
Vaseline applied				
Voided				
Stooled				
Nurses Initials				

Other: ____

Physician Notes:

Physician Signature: ________________________________ Date: ________ Time: ________

PRE-CIRCUMCISION ASSESSMENT AND PROCEDURE RECORD

PT.

MR.#/RM.

DR.