Patient Name_____

MR # _____

or Patient Sticker Only

CONSENT FOR NEONATE AND INFANT (0-12 MONTHS) CIRCUMCISION

☐ **FRICK HOSPITAL**
Mt. Pleasant, PA 15666

☐ **LATROBE HOSPITAL**
Latrobe, PA 15650

☐ **WESTMORELAND HOSPITAL**
Greensburg, PA 15601

Neonatal circumcision is an elective surgical procedure that is to be carried out only at the request of the parents. The American Academy of Pediatrics and The American College of Obstetricians and Gynecologists emphasize that existing scientific information suggests only a potential medical benefit. However, there is not sufficient claim to recommend routine neonatal male circumcision and the procedure is not essential to the infant's current well being. Non-circumcision is a reasonable and healthy alternative to circumcision.

American Academy of Pediatrics: March 1999

1. I hereby request that Dr. _____, and such assistants as may be selected by him/her, perform circumcision on my son, name _____. Circumcision is the procedure of removing a portion of the foreskin from the tip of the penis. **Circumcision is an elective surgical procedure.**
2. I acknowledge that the nature and function of circumcision and the non-circumcised alternative has been explained to me.
3. I have read the above statement of the American Academy of Pediatrics and have been explained and understand the benefits and risks of circumcision, including without limitation, scarring or injury to the penis, scrotum, or surrounding structures, incomplete circumcisions, infections and bleeding, which could be life threatening.
4. I understand that bleeding disorders such as hemophilia may be a contraindication of circumcision.

   Family history of bleeding disorders? ☐ **Yes** ☐ **No**

5. I consent to the administration of anesthetics considered necessary or advisable by the physician performing the procedure. The benefits and risks of the administration of such anesthetics have been explained to me.
6. If, during the course of the procedure, any unforeseen conditions arise which necessitate additional or different procedures, I further request and authorize the above-named physician or his/her designates to perform such procedure(s)/treatment(s), which in his/her professional judgment are necessary and desirable, including, but not limited to, procedures involving blood and blood products.
7. I hereby authorize Excela Health to dispose of the removed tissues, parts resulting from the procedure authorized above.
8. I acknowledge that all my questions have been answered satisfactorily and have all the information necessary to give informed consent.
9. No guarantees or assurances have been given by anyone as to the result of the procedure.
10. I consent to the admittance of clinical observers to the procedure room and to the clinical photographing and televising of the procedure(s) to be performed. All such pictures and films shall remain the exclusive property of Excela Health and shall be accorded the same level of confidentiality as a medical record.
11. BY MY SIGNATURE BELOW, I CERTIFY THAT I UNDERSTAND THE CONTENT AND MEANING OF THIS DOCUMENT AND I ACCEPT THE RISKS AND CONSENT TO THE PROCEDURE DESCRIBED ABOVE.

Parent/Guardian _____ Date/Time_____

Witness_____ Date/Time_____

Physician _____ Date/Time_____

Comments:_____

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