I, the parent or legal guardan of male infant _______________________________________, do hereby request and consent to the performance of a circumcision, or surgical removal of the foreskin from the penis. This procedure will be performed under the direction of Dr.(s):

____

____. I understand that this procedure is not medically necessary, and that I can choose not to have this procedure performed. In making this request and giving consent, I understand and agree that:

1. Circumcision is an elective procedure that carries a degree of both benefit and risk. Benefits may include prevention of urinary tract infections, sexually transmitted diseases and penile cancer. Potential risks include bleeding, local infections, and failure to remove enough foreskin or removal of too much foreskin. Complications from the procedure may include pain, bruising and inflammation at the opening of the penis.

2. I consent to the administration of such anesthetics as may be considered appropriate by the physicians responsible for this service.

3. I consent to the disposal by the hospital of any tissues that may be removed.

4. The purpose, nature, risks of and the alternatives to the procedure have been explained to me to my satisfaction by the above named doctor or his/her associates, and I realize that there is no certainty, or guarantee as to the results of the procedure. All my questions have been answered to my satisfaction.

5. I intend to be legally bound by this consent, which I am signing voluntarily after it has been completed and after having read and fully understanding it.

______________________	______________________	________	________
(Witness of Signature)	(Signature of Patient)	(date)	(time)

When patient is under eighteen (18) years of age or lacks capacity to give consent.

______________________	______________________	______________________
(Witness of Signature)	(Signature of person authorized to consent for patient)	(Relationship)

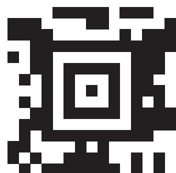
PHYSICIAN'S CERTIFICATION

I hereby certify that the patient or person authorized to consent for the patient did so after having been advised orally as to the nature, purpose, benefits, risks of, alternative options (including no treatment), risks of alternative options, likelihood of achieving goals of care, potential problems that may occur, the matters referred to in the consent, and after having received answers to any questions. By signing below, I indicate that the patient or person authorized to consent fully understands what I have explained and answered.

Physician______________________	______________________	________	________
(signature)	(printed name)	(date)	(time)

UPMC Pinnacle

CONSENT FOR CIRCUMCISION



Form 42542 (07/18) MR (InD)
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PATIENT IDENTIFICATION