Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

Cryopreservation of MESA-TESE Sperm

SRMS Consent Form

I understand that SRMS is a medical practice pursuant to the rules and regulations of the Florida Board of Medicine. I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have had an opportunity to ask questions regarding my procedure and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medications and/or the performance of particular procedures and wish to proceed with the treatment and procedures.

_____	___/___/___	_____	___/___/___
Patient	Date	Practitioner	Date
_____	___/___/___	_____	___/___/___
Guardian (if necessary)	Date	Witness	Date

Updated: 1/20/2010
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