



Pacific Clinic

PENILE PRP INJECTION PROCEDURE CONSENT FORM

CONSENT FOR PENILE PRP INJECTION PROCEDURE

- I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information.
- I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I have not received any promise, guarantee or warranty that my undergoing the Penile PRP Injection Procedure will achieve a particular result.
- I fully understand that individual results do vary, and that the Pacific Clinic, nor its physicians, assumes no responsibility for failure to achieve a desired result.
- I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below.
- I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

A. I authorize the physicians at the Pacific Clinic to treat my condition, including performing further diagnosis and the procedures described below, and taking any needed photographs.

B. I understand the proposed Penile PRP Injection Procedure(s): a procedure for rejuvenating, enlarging and strengthening the penis, using blood-derived growth factors (platelet rich fibrin matrix (PRFM), platelet-rich plasma (PRP) injections.

C. I understand the risks associated with the proposed procedure(s) to be:

- Bleeding
- Infections
- Urinary retention



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- No effect at all
- Allergic reactions
- Mental preoccupation of the penis
- Alteration of the function of the penis
- Sexual function alteration
- Hematoma
- Increased/worsening nocturia (waking up several times at night to urinate)
- Change in urinary stream
- Need for subsequent surgery
- Alteration of penile sensations
- Scar formation (penile)
- Local tissue infarction and necrosis
- Fatigue
- Alteration of bladder dynamics
- Post-operative pain
- Prolonged pain
- Intractable pain
- Alteration of the male sexual response cycle
- Failed procedure
- Varied results
- Psychological alterations
- Relationship problems
- Sex life alteration
- Decreased sexual function
- Possible hospitalization for treatment of complications
- Lidocaine toxicity
- Anesthesia reaction
- Embolism
- Depression
- Reactions to medications including anaphylaxis
- Nerve damage
- Permanent numbness
- Slow healing
- Swelling
- Sexual dysfunction
- Allergy



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- Nodule formation

D. I also understand that there may be other RISKS OR COMPLICATIONS, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

E. I understand that the use of PRP in this procedure is an “off-label” use, and no promise or representation, guarantee or warranty regarding its use, benefit or other quality is made. No representations that the use of this product and this procedure is approved by the FDA or any other agency of the federal or state government is made. I understand the alternatives to the proposed procedures and the related risks to be: do nothing.

CONSENT FOR ANESTHESIA

- When local anesthesia and/or sedation is used by the physician:
- I consent to the administration of such local anesthetics as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine.

PATIENT CERTIFICATION:

- By signing below I state that I am 18 years of age or older, or otherwise authorized to consent.
- I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.



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PATIENT NAME:

PATIENT SIGNATURE:

TODAY'S DATE:
