

INFORMED CONSENT FOR  
SEXUAL MEDICINE PROCEDURE(S) FOR ASSESSMENT OF MALE SEXUAL FUNCTIONING INVOLVING  
ERECTILE and/or EJACULATORY RESPONSES and MECHANISMS  
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In relation to my difficulties, concerns or complaints in the area of sexual functioning a form of targeted physical exam involving a clinical evaluation of certain specific parameters or aspects of my erectile and/or ejaculatory mechanisms has been suggested by my doctor. I understand that the goal(s) of this procedure include:

- (1) To gather direct clinical data that are specific and relevant to the state of my sexual arousal (erectile response) and/or ejaculatory mechanisms in response to penile vibrotactile stimulation (applied through the use of a medical device approved by FDA for clinic, as well as home, use for erectile and ejaculatory problems) and/or audiovisual stimulation for the purpose of a more detailed and individualized diagnosis (I understand that the data that will be obtained may include the timing and magnitude of erectile and/or ejaculatory responses; evaluation of certain reflexes that take part in the mechanism of erection and/or ejaculation, such as the bulbo-cavernosus reflex; assessment of sensitivity of my glans penis to vibratory stimuli; etc.)

and/or

- (2) To help guide in the choice of treatment options tailored to my specific clinical findings and needs, including an assessment of the potential for benefitting from a treatment plan involving the use of the Viberect device, as well as other treatment modalities, such as medications or behavioral treatment approaches;

and/or

- (3) To provide me with education and instruction with regard to the correct and effective use of a therapeutic device such as Viberect;

and/or

- (4) To provide me with professional feed-back, opinion, and, if appropriate, reassurance with regard to certain aspects of my sexual functioning when I have questions for my doctor in this area that can best be answered through this functional exam procedure;

and/or

- (5) To help monitor or assess the efficacy of my treatment.

I understand that I can opt not to have this specific examination. The alternative to this procedure is to proceed with assessment and treatment planning without the potential benefits outlined above.

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I understand that this medical examination procedure will be conducted under standard professional and clinical conditions, such as adhering to the principles of privacy and universal precautions with regard to possible transmission of pathogens from one individual to another.

I understand that I can opt to have my intimate partner, a close friend or relative, or another individual present during the procedure in some observant capacity.

I understand this examination involves the doctor's examination of my penis during its sexually functional state (during erection and/or ejaculation.) It does NOT involve any invasive procedure such as injecting, puncturing or cutting the skin or any other body part. In the absence of a pre-existing condition or trauma to the skin such as bruising, bleeding or superficial ulceration, the vibrotactile stimulation via the use of Viberect device is highly unlikely to be harmful or painful. The application of the Viberect device is known to carry a risk of autonomic dysreflexia specifically in *the spinal cord injured men* involving a rapid increase in the blood pressure due to excessive activation of the autonomic nervous system.

This examination procedure has been explained to me to my satisfaction and I have had sufficient opportunity to have my questions regarding the procedure answered by the doctor. Therefore, my signature below indicates that I give my informed consent for this procedure.

Full Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

SINAN DUZYUREK, MD, PLLC  
2440M STREET, NW SUITE 413  
WASHINGTON, DC 20037