WISPIVAS

Vasectomy Registration Form

For outreach or manual backup. Please print clearly. Staff will review your details before care.

Clinic or outreach site: _____

Date: _____ Beneficiary number (staff): _____

Personal details

Full name: _____

Date of birth: _____ Age in years: _____

Telephone: _____ Email (if available): _____

_____

Town or area: _____ Country: _____

ID or passport number (optional): _____

Marital status (optional): _____ Number of living children: _____

Emergency contact

Name: _____ Relationship: _____

Telephone: _____

Important information for your clinician

Allergies, medicines, medical conditions or previous scrotal surgery:

_____

_____

Contact and payment arrangements

May the clinic send care messages? Yes ☐ No ☐ Preferred: Phone ☐ Email ☐

Payment: Self funded ☐ Sponsorship requested ☐ Programme: _____

Confirmation

I confirm that these details are correct to the best of my knowledge. This registration form does not replace the separate vasectomy consent form.

Beneficiary signature or thumbprint: _____ Date: _____

Staff name and signature: _____ Date: _____