

TFNA

What you need to know
Before your procedure

Male Fertility and Sexual Medicine Specialists

MARTIN BASTUBA, M.D., F.A.C.S.

PRE-OP INSTRUCTIONS FOR TFNA

Your _____ has been scheduled for _____
(Date)
at _____ am/pm with Dr. Bastuba. Please check-in 15 min. early.
(Time)

Please carefully read and follow the steps below. Not completing these steps may cause your surgery to be rescheduled.

On the day prior to surgery:

1. Please eat a light meal the morning of your procedure with the Vicodin (or other med given). The meds should be taken 45 minutes prior to your procedure time. We will either mail you a prescription for your medication or you can call our office and give Alexia the phone number of the pharmacy of your choice.
2. Please shave scrotal sac, then shower prior to procedure or physician will shave site at time of surgery.
3. ***Very Important: Please bring an athletic supporter (snug fit) on the day of surgery.** Providing this support will minimize post operative swelling and discomfort.
4. A consent form for your procedure must be signed, dated and returned prior to surgery.
5. Please make arrangements to be driven home.
7. Please stop taking all blood thinners, aspirin and herbal products at least 7 days prior to surgery.
8. Payment arrangements must be made prior to your surgery. *If you are a *cash patient*, please know that payment is **due in full ten days** prior to surgery. Please contact our office at 619-286-3520 to make payment or regarding any questions.
9. **Your physician will send your specimen(s) to outside Pathology labs. You will be held responsible for all laboratory fees and you will receive a bill directly from these laboratories.**

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**ROUTINE POST-TESTICULAR FINE NEEDLE
ASPIRATION INSTRUCTIONS**

- (1) Spend the first 12 hrs. after the testicular fine needle aspiration off of your feet. Ice packs to the area will control swelling.
- (2) Leave athletic supporter and dressing in place for 24 hrs. If any activity causes pain, stop immediately.
- (3) After 24 hrs. remove the dressing and athletic supporter and shower for the first time. Replace the athletic supporter and continue to wear over the next three to five days if it provides comfort, otherwise it is unnecessary.
- (4) Take pain medication as needed for discomfort and antibiotics if prescription has been given.
- (5) Call the office promptly if:
 - (a) Significant bleeding occurs from the scrotal sites or within the scrotum (a small amount of blood is expected.)
 - (b) Fever of over 100 degree F.
 - (c) Pain and /or swelling is increasing over time.
- (6) It is okay to resume sex in approximately three days.
- (7) If you have any questions or doubts about your condition, please feel free to call. Someone will be available to answer your questions at 286-3520.

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PROFESSIONAL/SURGICAL FEE

Dr. Bastuba's fee is \$1,200.00 and is due at least 10 days prior to your procedure. We do accept cash, check and credit cards (Visa & Mastercard).

LAB FEES

There are additional laboratory fees for this procedure that you should be aware of before your procedure is scheduled. If insurance does not guarantee coverage, we require full payment 10 days prior to your procedure. If requested, we will bill your insurance as a courtesy to you. If your insurance does pay any portion of the procedure, you will be reimbursed that amount.

You will receive statements from Alvarado Community Hospital and the University College of San Francisco Medical Center for shipping, handling, transportation and reading of the specimen(s). These are laboratory fees that you will be expected to pay in addition to Dr. Bastuba's fee. The estimated cost ranges from \$300-\$400.

***If you have any additional questions regarding any of this information, please call Alexia at (619) 286-3520.**

CHECK-OFF LIST REMINDER

- Did you.....sign and return consent form?
- Did you.....pick up your medication?
- Did you.....pick up you athletic supporter?
- Did you..... make payment?

Thank you

Alexia Vinci
Bookkeeper / Surgery Scheduler

Testicular Fine Needle Aspiration Patient/Surgeon Consent Form

I, _____, authorize Martin Bastuba, M.D. to perform Testicular Fine Needle Aspiration.

I give consent for the use of an appropriate anesthetic agent and for possible evaluation of any removed tissue.

I understand this procedure to include aspirating tissue from one, and/or both testicles for the presence or absence of sperm.

I understand that I will be financially responsible for all laboratory fees from pathology to read each specimen/site and if sent for second opinion, any additional fees.

The procedures, alternatives and risks have been discussed and I wish to proceed with the surgery.

NAME (PRINT) _____ DATE _____

SIGNED _____ DATE _____
(Patient)

WITNESS _____ DATE _____