medica

טופס הסכמה
לניתוח גיד/ים ביד/ים

CONSENT FORM:
REPAIR OF FLEXOR/ EXTENSOR TENDONS

The surgery is performed in order to give the finger back its extension/flexion ability that was impaired as a result of cut-off tendon/s. The cut-off tendons are sutured end to end during surgery. If, during surgery, it turns out that the tendons cannot be sutured as aforesaid, the surgeon will use, to the extent possible, an alternative suturing technique in order to give the finger back is movement ability. The hand will be in cast for 4-6 weeks after the surgery.

The surgical incision sutures will be removed after approximately 10 days. During this time and afterwards, physical therpay, physiotherapy and occupational therapy will be necessary for several months.

The operation is performed under regional or general anesthesia combined with a tourniquet that is placed on the operated hand. The tourniquet could cause a sensation of pressure in the arm.

Patient's Name (שם המטופל/ת): _____ _____ _____ _____

Last Name / שם משפחה | First Name / שם פרטי | Father's Name / שם האב | ID No. / ת.ז.

I hereby declare and confirm that I have been given a detailed oral explanation by Dr. (מד"ר):

_____ _____

Last Name / שם משפחה | First Name / שם פרטי

on the need for flexor (מכופף/מכופפים), extensor (מיישר/מיישרים), tendon / tendons (גיד/גידים), right (ימין) / left (שמאל)* hand, digit (אצבע) 1 / 2 /3 / 4 /5* (henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation of the alternative modes of treatment that are possible in the circumstances of the case, including the prospects and risks involved in each of these procedures.

I was explained the desired results of the primary operation including the possibility that the tendons cannot be sutured as planned and the need to choose and alternative technique. I was also explained that in the majority of cases, the result will not be a full movement range as before the injury.

I hereby declare and confirm that side effects following the primary operation have been explained to me, including: pain, discomfort and swelling of the hand that will necessitate treatment. I was explained the expected effects after the removal of the cast including rigidity of the operated hand and fingers, that will necessitate physical therapy for several months, and sometomes repeated surgery to release adhesions.

I have also been explained the possible risks and complications, including: bleeding, infection and recurring tear of the sutured tendons. Repairing the tear will necessitate surgery for repeated suturing.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that it has been explained to me and I understand that there is a possibility that during the course of the primary operation, it will turn out that there is a need to broaden its scope, alter it or to perform other or additional procedures for the purpose of saving life or preventing physical damage, including additional surgical procedures that cannot now be anticipated

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with certainty or completely, but their significance has been made clear to me. I therefore consent to such broadening, change or the carrying out of other or additional procedures, including surgical procedures that the institution's physicians will consider to be vital or needed during the course of the primary operation.

My consent is hereby given also for regional anesthesia in combination with a tourniquet, after having had the possible risks of the anesthesia explained to me, including various degrees of allergic reaction to anesthetics, and the possibility of neural and/or vascular damage.

If it is decided to perform the operation under general anesthesia, an explanation of the anesthesia will be given to me by an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated physician, according to the institution's procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as they are performed in keeping with the standard degree of responsibility in the institution and in accordance with the law.

I, the undersigned, am aware that at the time of my discharge, the physician who operates on me might not be present in the hospital. In this case, I give my consent for any other physician to perform the discharge procedure on his behalf.

Date / תאריך	Time / שעה	Patient's Signature / חתימת המטופל/ת

Guardian's Name (Relationship) / שם האפוטרופוס (קרבה)	Guardian's Signature (for incompetent, minor or mentally ill patients) / חתימת האפוטרופוס (במקרה של פסול דין, קטין או חולה נפש)

I hereby confirm that I have given the patient (למטופל/ת) / the patient's guardian (לאפוטרופוס של המטופל/ת)* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

אני מאשר/ת כי הסברתי בעל פה למטופל/ת / לאפוטרופוס של המטופל/ת* את כל האמור לעיל בפירוט הדרוש וכי הוא/היא חתם/ה על הסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסברי במלואם.

Physician's Name / שם הרופא/ה	Signature / חתימה	License No. / מספר רישיון

* Cross out irrelevant option / מחק/י את המיותר