medica

טופס הסכמה
לניתוח לשחרור העצב המידאני/אולנרי
בתעלת שורש כף היד

CONSENT FORM: RELEASE OF CARPAL TUNNEL SYNDROME (CTS) RELEASE OF ULNAR NERVE - GUYON'S CANAL

This operation is performed in order to relieve the patient of pain that appears due to pressure on the median / ulnar nerve in the wrist.

The reason for the pressure is usually not known. In a minority of cases, a tumor or an anatomical change that is causing the pressure is found. In some cases, there is evidence of previous trauma.

The operation is performed by making an incision in the skin in the region of the wrist, releasing subcutaneous tissue and cutting the ligament that is pressing on the nerve. If additional findings are discovered during the operation, such as hyperplasia of tissue around the ligaments or scarring around the nerve, the surgeon will remove the hyperplastic tissue and will free the nerve of scars.

The incision is closed with sutures, which will be removed after approximately 7 to 14 days. The operation is performed under local and/or regional anesthesia combined with a tourniquet that is placed on the operated arm. 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. (ד"ר):

_____ _____

Last Name / שם משפחה | First Name / שם פרטי

concerning an operation to release the median (מדיאני) / ulnar (אולנרי)* nerve in Guton's Canal (the carpal tunnel) of the right (ימין) / left (שמאל)* arm (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, as well as of the side effects, prospects and complications that these treatments involve.

I have been explained the desired results of the primary operation as well as the possibility of slow recovery of the nerve. In a minority of case, the course of the recovery, accompanied by the side effects noted below, could be prolonged. The syndrome could recur on occasion, necessitating repetition of the operation.

I hereby declare and confirm that I have been explained the side effects following the primary operation, including: pain, discomfort, swelling of the hand and fingers, limitation to movement and subcutaneous hemorrhages that are spontaneously reabsorbed.

I have also been explained the possible risks and complications, including bleeding and infection that would require treatment.

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 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.

Habarzel 28, Ramat Hahayal, Tel Aviv, Tel: *2147 רחוב הברזל 28 רמת החייל, תל–אביב, טלפון:

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

If it is necessary to perform the primary 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 it is 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