medica

טופס הסכמה
לכריתת גנגליון

CONSENT FORM:
EXCISION OF GANGLION

A ganglion is a cyst containing viscous fluid that is usually formed around a tendon or joint. In most cases, the reason for its formation is not known. Ganglion exicision is performed in order to relieve the patient from pain or in order to remove an inaesthetic lump. The surgery is performed by making an incision in the ganglion area, freeing the tissues surrounding it, separating it from the joint or the tendon envelope from which it protrudes, and removing it.

If, during the surgery, there is suspicion that this is another type of tumor, the surgeon will decide whether to remove it whole, or whether at this stage, a biopsy for diagnosis will suffice. The incision is sutured with sutures that are removed several days later.

The operation is performed under local and/or regional anesthesia combined with a tourniquet that is placed on the operated hand, and sometimes under general anesthesia. The tourniquet might 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

on the need for ganglion excision in the right (יד ימין) / left (יד שמאל)* hand, from the wrist (משורש כף היד) / palm (מכף היד)*, on the palmar (בצד הכפי) / dorsal (בצד הגבי)* side, from digit (מאצבע) 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 have been explained the desired results of the primaryv operation as well as the high frequency of potential ganglion recurrence, and the need for another surgery for its excision.

I hereby declare and confirm that side effects following the primary operation have been explained to me, including: pain, discomfort, swelling and local self-absorbed hematomas.

I have also been explained the relatively rare risks and complications, including prolonged bleeding and infection that require treatment. Typically, physical therapy is not necessary after the operation.

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.

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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 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