medica

טופס הסכמה
לניתוח כריתת שקדים/אדנואידים
("שקד שלישי")

CONSENT FORM:
ADENOIDECTOMY/TONSILLECTOMY

Adenoidectomy / tonsillectomy is usually performed due to breathing difficulty and/or conditions of recurrent and/or chronic throat inflammation, sometimes as a procedure to prevent complications, and/or due to middle ear disturbances and/or developmental facial skeletal defects. The operation is performed under general anesthesia.

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 the need for adenoidectomy / tonsillectomy, due to (בשל) _____

_____ (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.

It has been explained to me that there are cases in which re-operation is necessary due the re-growth of the adenoids (the "third tonsil").

I hereby declare and confirm that I have been explained the side effects of the primary operation, including pain, discomfort and difficulty swallowing.

I have also been explained the possible risks and complications of the primary operation, including: immediate or delayed bleeding, making it necessary to return to the operating room in order to stop the bleeding, infection, difficulty swallowing, even to the extent of necessitating hospitalization for intravenous administration of fluids, injury to teeth, to the lips, to the gums and to the tongue, as well impairment of speech, including hypernasality, which will necessitate corrective surgery if it does not resolve. In rare instances, there may be scarring in the region of the operation, which could cause narrowing of the region of the pharynx and/or of the tube that connects to the middle ear (eustachian tube), which would be accompanied by functional impairment. The operation involves mortality in extremely rare instances.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that it has been explained to me and I have understood that there is a possibility that during the course of the primary operation, it will turn out that there is a need to be 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 explained 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.

It has been explained to me that the operation is performed under general anesthesia, and an explanation of the anesthesia will be given to me by an anesthesiologist.

I know and agree that the primary operation and all primary procedures 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.

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

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