medica

טופס הסכמה
לניתוח DCR – שחזור דרכי דמעות

CONSENT FORM:
DCR SURGERY - RECONSTRUCTION of the TEAR DRAINAGE CHANNEL

The aim of the operation is the improve tear drainage from the eye and to reduce the sensation of excessive tearing.

The operation is performed under general or local anesthesia.

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 hereby declare and confirm that the main post-operative side effects have been explained to me, including: pain, discomfort, redness and swelling of the eyelids, eyes and cheek.

I have been explained the possible risks and complications, including: infection, bleeding into the nose and subcutaneous hemorrhages around the eyes, sensation of a foreign body in the nose. The scar will be clearly visible for a number of weeks, after which it will blur to a large extent. It is, of course, possible that in spite of the operation, a new blockage of tear drainage will form and reoperation will be needed.

I hereby give my consent to perform DCR surgery - reconstruction of the tear drainage channel.

I hereby declare that it has been explained to me and and I have understood that there is a possibility that during the course of the treatment, 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 made clear to me. I therefore consent also 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 performing local anesthesia, after having had the risks and complications of local anesthesia clarified to me, including various levels of allergic reaction to anesthetics.

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

I am aware that in the event that the medical center has a university branch, during the evaluation and treatment, students may take part in under full control and supervision.

I consent that the hospital treatments be performed by the appointed person as stipulated in the hospital's regulations and rules, and I hereby declare that I was not promised that all of them or some of them will be performed by a specific person.

I, the undersigned, am aware that at the time of my discharge, the physician who carries out the treatment / 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.

Patient's / guardian's signature: _____
חתימת המטופל/ת / האפוטרופוס

0226 .כ.ו

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 to perform an operation in my ☐ **right (ימין)** eye;

☐ **left (שמאל)** eye (henceforth: "the primary operation").

_____ _____ _____

Date / תאריך | Time / שעה | Patient Signature / חתימת המטופל/ת

_____ _____

Name of Guardian (Relationship)/ שם האפוטרופוס (קרבה) | Guardian 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 / the patient's guardian / the patient's interpreter* a detailed oral explanation of all the above-mentioned facts and considerations as required and that the patient / the guardian 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 / אפוטרופוס של המטופל/ת / המתרגם/ת של המטופל* את כל האמור לעיל בפירוט הדרוש, השבתי על שאלותיו וכי המטופל/ת / האפוטרופוס חתם/ה על ההסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסברייי במלואם.

_____ _____ _____

Name of Physician / שם הרופא/ה | Signature / חתימה | License No. / מספר רישיון

_____ _____

Name of interpreter / שם המתרגם/ת | Relation to patient / קשריו למטופל/ת

* Cross out irrelevant option / מחק/י את המיותר