טופס הסכמה
לטיפול בלייזר YAG
לפתיחת ירוד משני

CONSENT FORM: YAG LASER TREATMENT to OPEN SECONDARY CATARACT

The use of YAG laser is intended for the treatment of the blurring of vision occurring after cataract surgery as the result of the opacification of the posterior capsule which holds the artificial lens (henceforth: “secondary cataract”). Using a laser beam, a small opening is created in the posterior capsule, allowing light to pass through it, thus improving visual acuity.

I have been given an explanation of the alternative modes of treatment that are possible in the circumstances of the case and in accordance with my condition, including the prospects and risks involved in each of these procedures, and the examinations and treatments involved.

I hereby declare and confirm that I have been given an explanation of the results that are hoped for and of the treatment’s side effects, including: during the initial hours after the treatment, there may be mildly blurred vision, however, improvement in vision is expected the day after the treatment. It has been explained to me that in the weeks following the treatment, I might see black, floating spots. These spots usually disappear. Additionally, it has been explained to me that after the treatment, a transient increase in intraocular pressure will be felt, which can usually be prevented with eye drops that I will receive at the end of the treatment.

The possible complications of the treatment have been explained to me, including: a risk of approximately 0.4% of retinal detachment.

I hereby give my consent to perform YAG laser treatment.

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 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 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

concerning the need to perform YAG laser treatment to open the posterior capsule due to secondary cataract in my ☐ **right (ימין)** ☐ **left (שמאל)** eye.

Patient's Signature / חתימת המטופל/ת:__________

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

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 (מטופל) / the patient's guardian (אפוטרופוס של המטופל)* a detailed oral explanation of all the above-mentioned facts and considerations as required, that I replied to his/her questions 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 / אפוטרופוס של המטופל/ת* את כל האמור לעיל בפירוט הדרוש, השבתי על שאלותיו וכי הוא/היא חתם/ה על ההסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסברי במלואם.

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

* Cross out irrelevant option / מחק/י את המיותר