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טופס הסכמה
לטיפול בסדק בפי טבעת

CONSENT FORM:
FOR REPAIR OF ANAL FISSURE

The treatment is designed to reduce the spasms of the anal sphincter to alleviate pain and to allow the fissure / wound in the anal lining to heal. Spasms can be reduced in two ways: first, manual expansion of the anal sphincter muscle and the second involves a cut (in an operation) of the internal sphincter muscle. The decision on the treatment method is made at the doctor's discretion and based on the findings.

The treatment is usually performed under general or regional anesthesia, and occasionally under 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.

In addition, it was made clear to me that there is no absolute certainty that the primary treatment will resolve the problem, and that additional treatment/s might be necessary.

I hereby declare and confirm that I have been given an explanation of the expected side effects that follow the primary treatment, including pain, discomfort and constipation.

I have also been explained the possible risks and complications, including bleeding, infection to development of an abscess, and the possibility of the formation of a fistula that occasionally requires additional operation. In addition, there is a risk of injury to the anal sphincter that might be manifested in flatulence incontinence and staining of underwear with mucous / feces, and to full incontinence of bowel movements. Most effects may spontaneously resolve within two months or after performing exercises to strengthen the anal and pelvic muscles. On rare occasions, the sphincter will be permanently damaged.

I hereby give my consent to perform the primary treatment.

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 treatment, 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, inter alia, based on the findings revealed in the examination performed under anesthesia (primarily when a suitable examination could not be performed before the operation due to anal pain). 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 treatment.

It has been made clear to me that the primary treatment is performed under general or regional anesthesia, and an explanation of the anesthesia will be given to me by an anesthesiologist.

My consent is hereby given also for performing local anesthesia, if the decision is made to perform the primary treatment under local anesthesia, after having had the possible complications of local anesthesia explained to me, including various levels of allergic reaction to anesthetics.

Patient's Signature / חתימת המטופל/ת: _____

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

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I know and agree that the primary treatment 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.

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

of the operation (ניתוח) / treatment (טיפול) of the anal fissure ANAL DILATATION / LATERAL SPHINCTEROTOMY / Other (אחר)*

Detail (פרט): _____(henceforth: "the primary treatment").

_____ _____ _____

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

_____ _____

Name of Guardian (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.

_____ _____ _____

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

* Cross out irrelevant option / מחק/י את המיותר