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טופס הסכמה
לניתוח לטיפול בהיפרדות רשתית

CONSENT FORM: REPAIR OF RETINAL DETACHMENT

Repair of retinal detachment is performed with the objective of attaching the retina to its place. The operation is performed by various methods, which in most instances are combined with the injection of a special substance into the eye. Retinal detachment is a condition in which the retina is detached from it position, and its ability to receive visual stimulation is impaired. The main causes of retinal detachment are: trauma, eye diseases (myopia, retinal degeneration) or systemic diseases such as diabetes. Treatment provided as early as possible is vital for the prevention of irreversible damage.

The operation is performed under local or general anesthesia.

I declare and confirm that it has been explained to me that there are no methods of treating retinal detachment other than an operation and/or the injection of gas to the eye.

I hereby declare and confirm that I have been given an explanation of the results that are hoped for, and of the fact that in some instances, additional operation/s is/are required to return the retina to its place.

I have been explained the side effects after the operation, including pain, discomfort redness and swelling.

I have also been explained the possible risks and complications, including: infection and refractive changes that would necessitate wearing spectacles or altering the previous spectacle prescription. More infrequent complications include: ptosis, double vision, elevated intraocular pressure, infections, and even absolute loss of vision in the operated eye and shrinking of the eyeball.

I hereby give my consent to perform the primary operation.

I hereby also 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 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 during the course of the primary operation.

My consent is given also for performing local anesthesia, after having been explained the risks and complications of local anesthesia, including bleeding, infection, damage to the eye, and in rare cases, loss of vision. If it is decided to perform the operation under general anesthesia, an explanation 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 it is performed in keeping with the standard degree of responsibility in the institution and in accordance with the law.

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, 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 carry out repair of retinal detachment in my right (ימין) / left (שמאל)* eye (henceforth: "the primary operation").

_____ _____ _____

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