medica

טופס הסכמה
לניתוח אקטרופיון

CONSENT FORM:
forEctropion surgery

The purpose of the surgery is to restore the eyelid to its normal position, restore function, and thereby prevent irritation, redness, discharge, tearing, pain and a foreign body sensation in the eye. This surgery does not improve the blurring of vision caused by other eye diseases and is not considered a cosmetic surgery. Sometimes surgery can be combined as part of lower eyelid cosmetic surgery.

Due to various factors of the ectropion, the different anatomy of each person and the existence of additional problems, there are a number of different surgeries to correct the problem. Most of them are correcting the weakness and drooping of the eyelid, tightening it to the eye and fixing it in the normal position. In some cases, tissue transplantation is needed to help repair the ectropion.

The surgery is performed in one of the following ways:

- Releasing the eyelid from its grip on the lateralsocket bone, releasing the tapering and tightly resewing back to the bone.
- Inversion stitchessutures that alter the eyelid position.
- Eyelid shorteningin combination with inversion stitches.

The form of anesthesia that accompanies this procedure: (circle the appropriate)

No Anesthesia (ללא הרדמה) / General (כללית) / Regional (אזורית) / Neural blockage (חסימה עצבית) / Local(מקומית)

I have been informed of the existing therapeutic alternatives for treatment of my condition such as: lubrication of the eye by various drops and ointments, fixing eyelid with a bandage, and, of course, carry on without treatment with all the suffering caused by the ectropion and risking serious damage to the eye up to the loss of vision and eye.

I hereby declare and confirm that I have been informed of the side effects, including: swelling around the eye, subcutaneous and subconjunctival hemorrhage, tearing, foreign body sensation and the need to remove the stitches after the surgery.

It has been explained to me and I understand that there is a possibility that during the course of an ectropion surgery, it will become necessary to perform therapeutic procedures for the operation, such as: washing tears, widening tear ducts, removing eyelashes.

In addition, I have been informed of the possible risks and complications including: recurrence of ectropion, under-repair, over-repair, infection, bleeding, asymmetric appearance, scarring, double vision, tearing or dryness of the eye, difficulty in wearing contact lenses, numbness or paresthesia near the eye, necrosis of the eyelid, change in the eye key, change of shape and placement of the angle of the eye and, in rare cases, loss of vision. Further treatment or surgery may be needed to treat these complications. Each person has a different anatomy, a different reaction to the surgery and different healing. Therefore, it is not possible to commit in advance to the final result.

I hereby declare and confirm that I have been informed and understand that there is a possibility that during the course of the main surgery / treatment it will become necessary to expand it, modify it or perform other or unforeseeable procedures to save lives or prevent bodily harm, including additional surgical procedures that cannot be fully or precisely predicted now. Therefore, I also agree to such expansion, modification, or performance of other or additional procedures, including actions that, in the opinion of the hospital physicians, will be vital or necessary during the main surgery / treatment.

It was explained to me that if the surgery is performed under **general / regional anesthesia / neural blockage**, an explanation regarding the anesthesia will be given to me by an anesthesiologist.

Patient's / Guardian's signature: _____
(חתימת המטופל / אפוטרופוס)

כ. 240

If performed under **local** anesthesia, my consent is also given for local anesthesia with or without intravenous injection of sedatives after I have been informed of the risks and complications of local anesthesia, including a varying degree of allergic reaction to the anesthetics and possible complications of sedatives that may rarely cause respiratory disorders and heart arrhythmias, especially in patients with heart disease and patients with respiratory disorders.

I know that in the event that the medical center has a university branch, students may take part in the evaluation and treatment under strict monitoring and supervision.

I know and agree that the main surgery (except if a surgeon has been selected and coordinated in advance) and all other procedures will be carried out by the person designated for it, in accordance with the procedures and instructions of the Institution, and that I have not been promised that they will be done, all or in part, by a specific person, provided that they are performed under the accepted responsibility of the Institution, subject to the law.

I, the undersigned, am aware that it is possible that on the date of my discharge, the physician who will operate on me, will not be present at the hospital, in which case I agree that another physician will perform my discharge procedure.

I hereby give my consent to perform the main treatment.

Name of Patient (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

On the need to perform an ectropion surgery (hereinafter: "the main surgery")

On the: ☐ **Right (עין ימין)** ☐ **Left Eye (עין שמאל)**

In the: ☐ **Top eyelid (עפעף עליון)** ☐ **Bottom eyelid (עפעף תחתון).**

_____ _____ _____

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 confirm that I have explained orally to the patient / the patient's legal guardian / the patient's translator* all the information detailed above in the necessary details, and that the patient / legal guardian has signed the consent in my presence after I was satisfied that my explanations were understood in their entirety.

אני מאשר/ת כי הסברתי בעל פה למטופל/ת / לאפוטרופוס של המטופל/ת / למתרגם של המטופל* את כל האמור לעיל בפירוט הדרוש וכי המטופל / האפוטרופוס חתם/ה על הסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסבריי במלואם.

_____ _____ _____

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

_____ _____

Translator's name (שם המתרגם/ת) Translator's relation to the patient (קשריו למטופל/ת)

* Cross out irrelevant option / מחק/י את המיותר