medica

טופס הסכמה
להזרקה תוך עינית

CONSENT FORM:
INTRA-VITREAL INJECTION

Diseases of the retina and choroid that cause reduction in visual acuity, quality of vision and visual field, on a background of the growth of pathological blood vessels in the eye and leakage from blood vessels in the choroid and retina, have been treated in recent years by injection into the eye of substances that suppress a protein called VEGF (Vascular Endothelial Growth Factor).

The main conditions in which an injection into the eye is performed are: growth of blood vessels from the choroid on a background of macular degeneration or other diseases, retinopathy on a background of diabetes, occlusions of blood vessels in the retina and edema of the retina. Additionally, there is a possibility of injecting steroids to the vitreous of the eye as a treatment for edema of the retina and uveitis.

The treatment is given under local anesthesia, at a frequency that is adapted to the patient's disease and his response to the treatment. It has been explained to me that the rate and duration of treatment depend on the level of response to the treatment. In most cases, repeat injections are required, sometimes monthly, for an unlimited amount of time.

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: other pharmaceutical preparations, photodynamic therapy and laser treatment. I have been explained the prospects for improvement, the side effects and the risks involved in each of these procedures.

It has been made clear to me that injection of Avastin to the eye, if performed, is given outside of the manufacturer's indications (OFF LABEL), and its long-term effects are not known.

I hereby declare and confirm that I have been explained the possible side effects of injection of the medication into the vitreous cavity, including: eye pain, subconjunctival hemorrhage, black spots in the visual field, edema or irregularity of the corneal surface, uveitis, visual disturbance, sensitivity to the injected medication and/or to the disinfectant and/or to the antibiotic given in the framework of the

treatment. In most cases, these side effects resolve by themselves or respond to treatment, but it is sometimes a long time until complete recovery.

I have also been explained the possible complications, including: retinal detachment, formation of cataract, elevated intraocular pressure,

intraocular hemorrhage and bacterial intraocular infection (endophtalmitis). In most cases, the complications can be treated with additional medications or operations, but in certain cases, these complications could cause absolute loss of vision and shrinking of the eye.

I hereby give my consent to perform the primary treatment, including the planned series of injections.

I hereby 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 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 the eye or preventing physical damage, including 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 treatment.

כ. 242

Patient's Signature / חתימת המטופל/ת:_____

My consent is given also for performing local anesthesia, after having been explained the risks and complications of local anesthesia given as eye drops, including: sensitivity, redness and discomfort.

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.

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 for an intra-vitreal injection to

☐ **the right eye (עין ימין)** (specify the name of the medication/s [ציין שם תרופה/ות]*: Avastin (אבסטין) / Lucentis (לוסנטיס) / Eylea (איליה) / Ozurdex (אוזורדקס) / other (אחר): _____)

☐ **the left eye (עין שמאל)** (specify the name of the medication/s [ציין שם תרופה/ות]*: Avastin (אבסטין) / Lucentis (לוסנטיס) / Eylea (איליה) / Ozurdex (אוזורדקס) / other (אחר): _____)

due to: ☐ wet macular degeneration (AMD) (ניוון מקולרי רטוב) ☐ macular edema (בצקת מקולרית)

☐ uveitis (דלקת הענביה) ☐ other (אחר): _____

_____(henceforth: the primary treatment).

_____ _____ _____

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