

**CONSENT FORM:  
PERFORMING MEDICAL  
CIRCUMCISION (SURGICAL)**

A circumcision (removal of the foreskin) is largely performed for religious, traditional and/or social reasons. Occasionally, a circumcision is required due to an inflammation of the foreskin that might result in urinary disorders. I have been explained that circumcisions can be performed by a mohel.

A circumcision / surgical circumcision is generally performed under local or regional anesthesia (penile block) and, occasionally, general anesthesia is necessary.

I hereby declare and confirm that I have been given an explanation of the anticipated results and side effects that are expected following the primary operation, including pain and discomfort.

I have also been explained the possible risks and complications, including: bleeding, injury to the head of the penis, infection and torsion of the penis.

I hereby give my consent to perform the primary operation.

My consent is hereby given also for performing local or regional anesthesia (penile block), if necessary, in accordance with the physician's judgment, after having had the possible complications of local anesthesia explained to me, including various levels of allergic reaction to anesthetics.

If it is decided to perform the primary operation under general anesthesia, an explanation of the anesthesia 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.

**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)      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 surgical circumcision (henceforth: "the primary operation").

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
Date / תאריך      Time / שעה      Patient's Signature / חתימת המטופל

\_\_\_\_\_      \_\_\_\_\_  
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) / the patient's guardian (למטופל של האפוטרופוס של המטופל) \* 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 / לאפוטרופוס של המטופל\* 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