medica

טופס הסכמה לניתוח למחיצת האף
ו/או כריתת/הקטנת קונכיות

CONSENT FORM: SMR/SEPTOPLASTY and/or CONCHOTOMY/TURBINATE REDUCTION

An operation to straighten or remove a deviated nasal septum (SMR / septoplasty) is performed when air flow is obstructed to the point of interfering with breathing. There are cases when an obstruction to air flow is caused by a enlargement and swelling of the nasal conchae, which are located on the lateral walls of the nose, with our without a deviated septum. In these cases, removal (כריתת) / reduction (הקטנת) / cautery (צריבת) of one or both inferior conchae (turbinates) will be required (conchotomy / turbinate reduction).

The surgery is performed in the nose without any external incisions. The surgeon will determine whether to leave stents or tampons in the nasal cavity.

The operation is performed under general anesthesia or local anesthesia together with injection of tranquillizer.

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 SMR / septoplasty (תיקון מחיצה) and/or (ו/או) conchotomy (כריתת הקונכייה/ות) /

turbinate reduction (הקטנת הקונכייה/ות) on the (בצד) _____ side due to (בשל)

_____ (henceforth: "the primary operation").

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, as well as of the side effects, prospects and complications that these treatments involve.

I have been explained that there are cases in which the surgery will not resolve the functional problem.

I hereby declare and confirm that I have been explained the side effects of the primary operation, including: pain and discomfort, bleeding, scabs and bad odor in the nose, and reduced sensation (usually temporarily) of the upper teeth and hard palate.

In addition, the possible risks and complications of the primary operation have been explained to me, including: sinusitis; septum perforation that might cause wheezing, scabs and bleeding; adhesions between the septum and the conchae; change in the exterior shape of the nose; impaired sense of smell (rare); dryness in the nose; significant bleeding that requires repeat surgical intervention; life-threatening infection from the tampons, abscess in the septum that requires surgical drainage.

I hereby give my consent to perform the primary operation.

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 operation, 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 life or preventing physical damage, including additional surgical procedures that cannot now be anticipated with certainty or completely, but their significance has been explained to me. I therefore consent also to such broadening, change or the carrying out of other or additional procedures, including surgical

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procedures that the institution's physicians will consider to be vital or needed during the course of the primary operation.

My consent is hereby given also for performing local anesthesia, with or without intravenous injection of sedatives, after having been explained the risks and complications of local anesthesia, including various levels of allergic reaction to anesthetics, and the possible complications of the use of sedatives, which could, in rare cases, cause disturbances to breathing and disturbances to heart function, mainly in people with heart disease and people with disorders of the respiratory system.

It has been explained to me that if the operation is performed 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.

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(המטופל/ת) (לאפוטרופוס של)* 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