medica

טופס הסכמה
לניתוח עפעפיים

CONSENT FORM:
BLEHAROPLASTY

The objective of the operation is to remove surplus skin and fat tissue in the eyelids. The operation does not remove wrinkles at the corners of the eyes. The operation can be performed as part of a facelift.

The operation is usually performed under local anesthesia with the addition of tranquillizers.
It has been explained to me that I will (נדרש) / will not (לא נדרש)* need to have the eyelid stretched sideways or upwards.
I hereby declare and confirm I have been explained the side effects that follow the primary operation, including: pain, discomfort, swollen eyelids, dryness of the conjunctiva or tearing, subcutaneous hemorrhages around the eyes, red eyes and an itching sensation. The scars will be clearly visible for a number of weeks, after which they will blur to a large extent.
The possible complications have also been explained to me, including: infection, the appearance of cysts in the region of the sutures, prominent scars, changed shape of the aperture between the open eyelids, eyelid traction, damage to the lacrimal glands causing dryness of the conjunctiva or tearing, chronic pain in the operated region, temporary or permanent loss of eyelashes, asymmetry between two sides of the eye, and in rare cases, bleeding which would necessitate an urgent operation.
I hereby give my consent to perform 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 the anesthetics, and possible reactions to sedatives, which might, rarely, cause disturbances to breathing and disturbances to heart function, mainly in people with heart disease and people with disorders of the respiratory system.
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/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 an operation of the upper (עליון) / lower (תחתון) eyelid / both eyelids (שני העפעפיים)* of the right (ימין) / left (שמאל) eye / both eyes (שתי העיניים)* (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 המיות

כ. 233