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טופס הסכמה
לניתוח לשאיבת שומן

CONSENT FORM:
LIPOSUCION

Liposuction is a surgical technique intended for the removal of concentrations of surplus fat from defined regions of the body. The operation does not constitute a substitute for weight loss. Following liposuction, there may sometimes be a need for an operation to remove surplus skin.

The operation is performed under general, regional or local anesthesia.

I have been given an explanation of the alternative modes of treatment that are possible in the circumstances of the case, including: removal of surplus skin and fat, the prospects and complications of each of these procedures, and the examinations and treatments involved.

I have been given an explanation of the results that are hoped for and of the limitations of the corrective capacity of the operation, i.e. on occasion, liposuction will not achieve the desired results and/or it will manifest as non-uniform contraction of the skin and the appearance of troughs or protrusions on the surface. Bilateral liposuction could result in asymmetry.

I hereby declare and confirm that I have been explained the side effects that follow the primary operation, including pain, discomfort, and temporary or permanent changes in skin sensation. It has been explained to me that in places where the liposuction instrumentation is introduced, scarring will remain. The scars that will remain depend on the type of skin that I have and its healing characteristics, and there are cases in which keloidal scars develop.

I have also been explained the possible risks and complications, including: bleeding, infection and accumulation of fluids (seroma) in the areas where liposuction is performed. There may also be skin damage, inflammation of veins- superficial and/or deep, and in extremely rare instances, pulmonary emboli.

I hereby give my consent to perform the primary operation.

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, including additional surgical procedures that cannot now be anticipated with certainty or completely, but their significance has been made clear to me. I therefore consent 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 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 rarely could cause disturbances to breathing and disturbances to heart function, mainly in people with heart disease and people with disorders of the respiratory system.

If it is decided to perform the operation under general or regional anesthesia, an explanation of the anesthesia will be given to me by an anesthesiologist.

Patient's Signature / חתימת המטופל/ת:_____

Habarzel 28, Ramat Hahayal, Tel Aviv, Tel: *2147 רחוב הברזל 28 רמת החייל, תל–אביב, טלפון:

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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 liposuction from the (מאזור) _____ area (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 המיותר