medica

טופס הסכמה
לצילום רחם

CONSENT FORM FOR HYSTEROGRAPHY

A hysterography is performed to diagnose defects in the uterus and fallopian tubes when there is fertility disorder, i.e., inability to become pregnant or maintain a pregnancy.

To perform the test, a device is used that holds and fixates the cervix. Through the cervix, a tube is inserted by which radiographic contrast material that contains iodine is injected. Afterwards, an x-ray and several x-rays are taken.

The test is carried out after the menstrual cycle has ended (in the first half of the menstrual cycle) without anesthesia.

If the last menstrual cycle was abnormal, inform the doctor before the examination in order to consider a possible pregnancy.

If you have a known sensitivity to iodine, inform the doctor and x-ray technician.

During the summons to the examination, I have been informed that I must avoid sexual relations from menstruation and until the test, to rule out the possibility of performing the test during pregnancy, which might result in a miscarriage or fetal damage attributed to the use of contrast material and exposure to radiation.

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 hereby declare and confirm that I have been given an explanation that during the primary examination, pain in the pelvic and abdominal region is generally expected (due to uterine contraction) that generally lasts shortly after the procedure is performed, and that mild vaginal bleeding might occur.

In addition, I have been given an explanation of the possible risks and complications, including: infection, recurrence of chronic pelvic inflammation, allergic reaction of varying degrees of the contrast material, and, on rare occasions, perforation of the uterus.

I hereby also declare and confirm that it has been explained to me and I have understood that in the case of a serious infection or perforation of the uterus during the examination, it might be necessary to perform life saving corrective procedures or for preventing physical damage, including surgical procedures that cannot now be anticipated with certainty or completely, but their significance has been made clear to me, including the need, on rare occasions, for a hysterectomy.

I hereby give my consent to perform the primary examination.

I know and agree that the primary examination 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.

Patients signature: _____ :חתימת המטופל/ת

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

Woman's Name: _____ _____ _____ _____

(שם האישה) 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

of the hysterography, its purpose and how it is performed (Henceforth: "The Primary Examination").

_____ _____ _____

Date / תאריך Time / שעה Woman's Signature / חתימת האישה

_____ _____

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 (לאישה) / the patient's guardian (לאפוטרופוס של האישה)* 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 לאישה / לאפוטרופוס של האישה* 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