medica

טופס הסכמה
להיסטרוסקופיה

CONSENT FORM FOR HYSTEROSCOPY

A hysteroscopy is a procedure that allows for a direct observation of the uterine cavity to diagnose illnesses and to perform surgical procedures in the uterine cavity.

A diagnostic hysteroscopy can be performed without anesthesia or with the assistance of one of the available types of anesthesia, including the possibility of combining them. A surgical hysteroscopy is performed under regional or general anesthesia. To perform a hysteroscopy, the uterine cavity must be dilated with the use of CO_2 gas or liquid.

Following the procedure, a rest of several hours is required in hospitalization, followed by rest at home. A check-up at the clinic will be carried out according to the doctor's instructions.

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 explained the side effects of the primary procedure, including: abdominal pain, pain in the diaphragm and shoulders, discomfort and mild bleeding that generally disappears within several days.

I have also been explained the possible risks and complications, including infection, bleeding and/or perforation of the uterus that would require corrective surgery. On rare occasions, infection or perforation of the uterus will require a hysterectomy and on even rarer occasions, damage to other abdominal organs might occur, requiring corrective surgery.

I was given an explanation of the possible complications of insertion of fluid into the uterine cavity, including: hyperabsorption of fluids into the blood system and, on rare occasions, pulmonary edema and/or "water toxicity". In addition, I was given an explanation of possible complications of the insertion of gas into the uterine cavity, including: air embolism in the lungs, heart or brain and, on extremely rare occasions, death.

I hereby give my consent to perform the primary procedure.

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 procedure, 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 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 procedures that the hospital's physicians will consider to be vital or needed during the course of the primary procedure.

My consent is hereby given also for performing local anesthesia, with intravenous injection of sedatives, after having been explained the risks and complications of local anesthesia, including various levels of allergic reactions 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.

0203.ט

Patient's Signature / חתימת המטופל/ת:_____

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

I know and agree that the primary procedure 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.

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

concerning the need to perform diagnostic (אבחנתית) / surgical (ניתוחית)* hysteroscopy (henceforth: "The primary procedure").

_____ _____ _____

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

_____ _____

Name of Guardian (Relationship)/ שם האפוטרופוס (קרבה)

Guardian 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.

_____ _____ _____

Name of Physician / שם הרופא/ה Signature / חתימה License No. / מספר רישיון

* Cross out irrelevant option / מחק/י את המיותר