medica

טופס הסכמה
לניתוח להורדה ולקיבוע
של אשך טמיר

CONSENT FORM:
ORCHIOPEXY (UNDESCENDED TESTIS)

An undescended testis is a congenital defect in which the testis did not complete its descent to the scrotum.

The objective of the operation is to move the testis down into the scrotum and to fixate it there, with the objective of preventing impairment to fertility and in order to enable early detection of other pathological states. The operation is performed through an incision in the groin, during which the testis, the vas deferens and the blood vessels of the testis are separated from the hernia sac and from any other adhesions in the region, in order to make it possible to move the testis down to the scrotum. In cases where it turns out during the operation that the blood vessels of the testis are too short, the operation might be performed in two separate stages, or it may be necessary to disconnect blood vessels of the testis from the abdominal area. This procedure is liable to cause degeneration of the testis. In the event that the undescended testis is found to be defective or undeveloped, and it cannot be moved down into the scrotum, it is advisable to remove it. The operation is performed under general anesthesia.

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 an orchiopexy to bring down a right (ימני) / left (שמאלי)* undescended testis (henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation of the hoped for results of the primary operation, i.e. the provision of the best possible chance for normal development of the testis. However, it has been explained to me that an undescended testis may be defective from the outset, and it may therefore be necessary to remove it. Even if the testis is found to be normal, there is no guarantee that the testis will continue to develop normally and/or that it will not return to the groin, which would necessitate a further operation.

It has been explained to me that there are no alternative ways to treat an undescended testis.

I hereby declare and confirm that I have been given an explanation of the side effects that follow the primary operation, including pain and discomfort.

I have also been explained the possible risks and complications, including: infection, bleeding, damage to the vas deferens and/or to the blood vessels of the testis and/or to the testis, causing its degeneration.

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 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 made clear to me. I therefore consent also to such broadening, change or the carrying out of other or additional procedures, including

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

It has been made clear to me that the primary operation is performed under general anesthesia, and 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 (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