medica

טופס הסכמה
לניתוח לתיקון פזילה

# CONSENT FORM:
# OPERATIONS ON
# EXTRAOULAR MUSCLES

The operation is performed in order to improve the relative position of the eyes, by shortening and/or lengthening the extraocular muscles, which are responsible for eye movements. The operation does not change the visual acuity of each eye, but rather it changes the patient's appearance, and sometimes binocular function. The operation is a therapeutic option in a series of possible treatments, which include, among others: wearing eyeglasses and/or covering one eye as a treatment for lazy eye. These treatments are carried out before and/or after the operation. In each operation, one or two muscles are operated on, in one or both eyes, depending on the condition.

The operation is performed under general or local 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 operation on extraocular muscles in the right eye (עין ימין) / left eye (עין שמאל) / both eyes (שתי עיניים)*, on one muscle (שריר אחד) / two muscles (שני שרירים)* (henceforth: "the primary operation").

I declare and confirm that I have been given an explanation of the results of the operation that are hoped for, which include changes in the angle of squint, including a gradual additional gradual improvement or worsening, i.e. return to the previous angle of squint or the appearance of a different type of squint. In such cases, there is the option of an additional operation.

I have been explained the side effects after the operation, including pain and discomfort.

I have also been explained the possible complications and risks during the course of the operation, including: hemorrhage, infection, and in extremely rare cases, reduction in vision.

I hereby give my consent to perform the primary operation.

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

My consent is given also for performing local anesthesia, after having been explained the risks and complications of local anesthesia, including: bleeding, infection, damage to the eye, and in rare cases, loss of vision. If it is decided to perform the primary operation under general anesthesia, 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.



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

**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