יש למסור עותק למטופל

טופס הסכמה להסרת גידול / נגע מהעפעפיים

CONSENT FORM: REMOVAL of an EYELID TUMOR / LESION

מדבקה גדולה

The aim of the operation is to remove the lesion from the eyelids in its entirety, or if this is not possible, then a part of it for the purpose of diagnosis.

The operation is usually performed under local anesthesia (with the addition of tranquillizers in rare cases).

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, including the prospects and risks involved in each of these procedures.

I hereby declare and confirm that the main post-operative side effects have been explained to me, including: pain, discomfort, swollen eyelids, dryness of the conjunctiva or tearing, subcutaneous hemorrhages around the eyes, red eyes and an itching sensation.

The scars may be clearly visible for a number of weeks, after which they will blur to a large extent.

The possible complications have been explained to me, including: infection, the appearance of cysts in the region of the sutures, prominent scars, changed shape of the aperture between the open eyelids, pulling of an eyelid, damage to the lacrimal gland causing dryness of the conjunctiva or tearing, loss of the tear drainage passages with permanent tearing, chronic pain in the operated region, temporary or permanent loss of eyelashes, asymmetry between two sides of the eye, and in rare cases, bleeding which would necessitate an urgent operation. Additionally, the finding could recur necessitating reoperation.

I hereby give my consent to perform the primary operation.

I hereby declare that it has been explained to me and I have understood that there is a possibility that during the course of the operation, 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 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, after having had the risks and complications of local anesthesia clarified to me, including various levels of allergic reaction to anesthetics.

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

I am aware that in the event that the medical center has a university branch, during the evaluation and treatment, students may take part in under full control and supervision.

I consent that the hospital treatments be performed by the appointed person as stipulated in the hospital's regulations and rules, and I hereby declare that I was not promised that all of them or some of them will be performed by a specific person.

I, the undersigned, am aware that at the time of my discharge, the physician who carries out the treatment / 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 / Guardian's signature: _____
(חתימת המטופל / אפוטרופוס)

HOSPITAL Assuta
RAISING HEALTH STANDARDS

- חסוי רפואי -
(לאחר המילוי)

יש למסור עותק למטופל

מדבקה גדולה

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 the need to perform an operation of the

☐ **right (עין ימין)** eye

☐ **left (עין שמאל)** eye, in the

☐ upper (עפעף עליון) ☐ lower (עפעף תחתון) eyelid, ☐ medial (קנטוס מדיאלי) ☐ temporal (קנטוס טמפורלי)* canthus - (henceforth: "the primary operation").

_____ _____ _____

Date / תאריך | Time / שעה | Patient Signature / חתימת המטופל/ת

_____ _____

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 / the patient's guardian / the patient's interpreter* a detailed oral explanation of all the above-mentioned facts and considerations as required and that the patient / the guardian 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 / אפוטרופוס של המטופל/ת / המתרגם/ת של המטופל* את כל האמור לעיל בפירוט הדרוש, השבתי על שאלותיו וכי המטופל/ת / האפוטרופוס חתם/ה על ההסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסברי במלואם.

_____ _____ _____

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

_____ _____

Name of interpreter / שם המתרגם/ת | Relation to patient / קשריו למטופל/ת

* Cross out irrelevant option / מחק/י את המיותר