

ט"ס/OSURG/UROL/0640/0280/דצמבר 2006

טופס הסכמה: ביצוע מילה רפואית/כריתת ערלה (כירורגית)

### CONSENT FORM: CIRCUMCISION

Circumcision (excision of the foreskin) is usually performed for religious, traditional or social reasons. Sometimes the need arises for excision of the foreskin because of inflammation of the foreskin that may cause difficulties in passing urine.

It has been explained to me that circumcision may be performed by a mohel.

Circumcision/surgical excision of the foreskin is usually performed with local or regional (penile block) anesthesia and sometimes general anesthesia is necessary.

Name of Patient: \_\_\_\_\_  
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:

Dr. \_\_\_\_\_  
Last Name First Name

concerning the performance of surgical circumcision (hereafter: "the main operation").

I declare and confirm that I have been given an explanation regarding the desired results and side effects to be expected after the main operation including pain and discomfort.

Also, the possible complications and risks have been explained to me, including: injury to the glans (head) of the penis, infection and torsion of the penis.

I hereby give my consent to performance of the main operation.

I am aware that a transfusion of blood or blood products, such as concentrated red blood cells, fresh plasma, concentrated platelets or cryoprecipitate is given to patients in need of such a transfusion, via an intravenous drip, during surgery or other medical procedures – in light of illness, blood loss, or a lack of blood or one of its components. The administration of blood or blood products is intended to save the life of the patient and to improve his/her chances of recovery and recuperation.

Collection and testing of blood and/or blood products for a transfusion is performed in strict compliance with the guidelines outlined by the Ministry of Health. In addition, the compatibility of the blood units and the blood products with the recipient patient is verified. Nevertheless, there is a very small risk that there may not be full compatibility between the blood and/or blood products and the patient's body, and that, as a result, the patient may suffer an allergic reaction, which will be manifested by fever, rash or chills. These reactions can be successfully treated. In rare cases, a hemolytic reaction (destruction of red blood cells) may occur, which in extreme cases can impair kidney function and even be fatal. In addition, despite the fact that the blood units and the blood products for transfusion are prepared at the Blood Bank, using the most up-to-date methods for detection of possible contamination, there is a small chance of patient infection. This infection may not be detected for a period of months or even years. The risk of becoming infected with viral hepatitis or AIDS (the human immunodeficiency virus) exists, but is extremely rare.

However, the risk to the health of the patient as a result of not receiving the blood or blood-product transfusion during surgery or medical treatment is much greater than the risks inherent in receiving the transfusion. The risks in not receiving blood or blood products include increased length of hospitalization, failure of the medical treatment provided, medical complications, and in certain cases, even death.

In view of the above, I consent to receive a blood transfusion, as justified by my medical condition.

My consent is also given hereby to the performance of local or regional (penile block) anesthetic if the need arises for such, at the discretion of the physician after the possible complications of local anesthetic have been explained to me, including an allergic reaction of varying degrees to the anesthetic materials.

If it is decided to perform the main operation under general anesthetic, I will receive an explanation regarding the anesthesia from the anesthetist.

I know and agree that the operation and all the main operations and all other procedures will be carried out by whoever is designated to do so, according to the institutional procedures and directives of the institution and that it has not been promised to me that they will be carried out in whole or in part by a specific person, but only that they will be performed under the standard degree of responsibility of the institution, according to law.

Date	Time	Patient Signature
Name of Guardian (Relationship)	Guardian's Signature (for incompetent, minor or mentally ill patients)	

I hereby confirm that I provided the patient / the patient's guardian\* with a detailed verbal explanation of all the above mentioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician Signature	License No.
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\* Cross out irrelevant option.



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 Surgery



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