מדבקת המטופל

Consent form

ESS / Functional Endoscopic Sinus Surgery (FESS)

Endoscopic sinus surgery is carried out in most cases due to recurring sinusitis incidents, chronic sinusitis that does not respond to pharmaceutical treatment, or polyps in the nose and sinuses that do not respond to traditional treatment. Sometimes the operation is carried out due to tumors, cysts, foreign bodies or fungus. The objective of the procedure is to remove the disease and improve drainage and ventilation of affected sinuses. The extent of the procedure is determined by clinical and x-ray findings and may be revised during the procedure.

The procedure uses access through the nose without external incisions, using an endoscope, an optical device that enables the surgeon to see the operated area close up and enlarged. After the procedure, the surgeon may leave tampons in the nose that cause discomfort. A procedure to correct deviation of the nasal partition and/or remove/decrease the nasal concha may sometimes be included.
Surgery is carried out under local or general anesthesia.

Patient's name: _____
Last name First name Father's name ID no.

I hereby declare and confirm having received a detailed oral explanation from Dr. _____
Last name First name

About the need for sinus surgery with/without nasal partition surgery, with/without nasal concha surgery on the _____ side

Due to _____ (hereinafter: "the procedure")

I was informed that in some cases repeated surgery may be required due to recurrence of the disease, chronic secretions or lack of a proper functional result. In some cases more than one procedure may be scheduled in advance.

I hereby declare and confirm that I received an explanation about the side effects of the procedure, including pain and discomfort.

Furthermore, I received an explanation about the possible risks and complications of the procedure, including: bleeding, infection of the operated area, scarring and sticking of nasal tissue or sinuses to the point of requiring a repeated procedure, impaired sense of smell, nasal dryness, damage to the eye socket – from slight problems such as small hemorrhaging or air in the eyelids to damage to the sight muscles or vision leading to blindness in rare cases, damage to the tear ducts, damage to brain tissues with leakage of brain liquids or meningitis, and in extremely rare cases inner-brain damage. In extremely rare cases the procedure may cause mortality.

I hereby give my consent to performance of the procedure.

I hereby declare and confirm that I have received an explanation and am aware of the possibility that in the course of the procedure the need may arise to extend its scope, modify it or use other or additional procedures to save life or prevent physical damage, including additional surgical procedures that cannot be foreseen certainly or fully at this stage, but their significance has been explained to me. I therefore also consent to said extension, modification or other or additional procedures, including surgical actions institution physicians believe to be vital or required during the course of the procedure.

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.

I hereby give my consent to undergoing local anesthetics with or without intravenous injection of sedatives, after having received an explanation about the risks and complications of local anesthetics including various degrees of allergic reaction to the sedatives and possible complications due to the use of sedatives that may, rarely, cause respiratory disorders or cardiac disorders, particularly among cardiac patients and those with respiratory system disorders.

I was informed that should the procedure be performed under general anesthesia the anesthetist would give me a relevant explanation about it.

I am aware that and consent to the procedure and all other procedures to be carried out by the person to whom it was allocated according to the institution's procedures and instructions, and I have not received any assurance that the procedure or a part thereof will be carried out by a particular person, provided it is carried out within the responsibility accepted by the institution and subject to the law.

_____

Date Hour Patient's signature

_____

Guardian's name (relationship) Guardian's signature (in case of incompetency, minor or mental patient)

I hereby confirm that I provided the patient/the patient's guardian* with an oral explanation of all of the above in required details and s/he signed the consent before me after I was convinced s/he fully comprehended my explanation.

_____

Physician's name Physician's signature License no.

* Strike out the irrelevant item

Israeli Medical Association **Medical Risk Management Company Ltd.**