

Consent form: SMR/Septoplasty and/or Conchotomy/Turbinate Reduction)

SMR/septoplasty/conchotomy/turbinate reduction surgery is carried out in cases where air flow is obstructed to the point of restricting respiration. In some cases, obstruction to air flow is caused by growth and swelling of the nasal conchae on the nasal lateral septums, with or without deviation of the septum. In these cases, one or both lower conchae may have to be removed/decreased/seared.

Surgery is carried out inside the nose, without any external sections. The surgeon will decide whether to leave supports or tampons in the nasal cavity.

Surgery is usually carried out under general or local anesthesia with sedation.

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

About the need for SMR/septoplasty/conchotomy/turbinate reduction surgery on the _____ side due to _____ (hereinafter: "the procedure")

I was informed that in some cases, this surgery will not solve the functional problem.

I hereby declare and confirm that I received an explanation about the side effects of the procedure, including pain and discomfort, hemorrhaging, scabs and odor in nose, decrease (usually temporary) in sensitivity of the upper teeth and the frontal part of the palate.

Furthermore, I received an explanation about the possible risks and complications of the procedure, including: sinusitis, perforation of the septum that may cause wheezing, scabs and hemorrhages, adherence of septum to conches, modification to the external form of the nose, impaired sense of smell (rare), dryness of the mouth, significant hemorrhaging requiring repeated surgical intervention, life threatening infection from tampons, abscess in septum requiring surgical drainage.

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 am also providing 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 reactions to sedatives and possible complications due to the use of

החברה לניהול סיכונים ברפואה בע"מ



ההסתדרות הרפואית בישראל
איגוד רופאי אף-אוזן-גרון וכירורגיה של ראש צוואר



sedatives that may, rarely, cause respiratory disorders or cardiac disorders, particularly among cardiac patients or those with respiratory system disorders.

I was informed that should the procedure be performed under general anesthesia, the anesthetist will 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
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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.
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* Strike out the irrelevant item

Israeli Medical Association

Medical Risk Management Company Ltd.

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