Patient's sticker

Version 08/16

Consent Form For

EPIDURAL BLOOD PATCH INFORMED CONSENT

Injection of self-blood taken from my body and injected into the an epidural space, is an invasive procedure which aims to stop or relieve headaches caused by low pressure of the cerebrospinal fluid. Low pressure of the cerebrospinal fluid may occur following an epidural injection, spinal injection, diagnostic or treatment lumbar puncture, or for no apparent reason. A drop in spinal fluid pressure is caused by leakage of spinal fluid from the spinal space, thus causing headaches.
During this operation blood taken from a vein is injected into the epidural space in order to reduce the leakage of cerebrospinal fluid through the hole in the dura membrane that surrounds the spinal cord.

Patient Name:

Last Name	First name	ID.	Father's Name

I hereby declare and confirm that I received a detailed oral explanation from Dr.:

Last Name	First name

of the need to perform self blood injection (hereinafter: the "Primary treatment").

I have been informed that the act of self-blood injection is one of the conventional methods to treat headaches of this type and that it is performed after conservative treatment has failed. In this operation the anesthesiologist will perform epidural puncture another staff member will simultaneously suck blood from my vein in a sterile manner. The blood will be immediately injected into the epidural space until I feel pressure in my back or neck.

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I have been informed that after the operation there is a chance of up to 30% that the pains will not pass completely and in some cases it will be necessary to repeat the operation. Even after the second time the headaches do not always go away completely.
I have been informed that there is a slight risk of puncturing the dura membrane or a blood vessels in the area. Rarely an infection may develop where the operation is performed, or in the central nervous system, nerve damage, weakness, paralysis or other neurological signs in the lower body.

I acknowledge that if the medical center has a university branch, student may take part in the evaluation and treatment procedures, under full supervision.
If the operation is carried out within the public health system, it was made clear to me and I know and agree that the operation will be done by whoever is designated to do so in accordance with procedures.
I hereby grant my consent to perform the primary treatment.

Date	Time	Patient Signature

Guardian's name (relatedness to the patient)	Guardian's signature (in the case of an incompetent minor or mentally ill)

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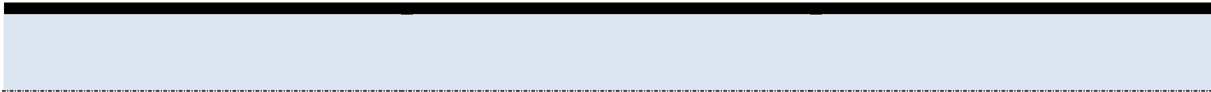
I confirm that I orally explained to the **patient/guardian/patient's translator** all the above in the required detailing, and that he/she signed a consent before me after I was convinced that he/she fully understood my explanations.



Physician's name (stamp)	Physician's signature	Date and time

Translator's name	His relatedness to the patient