Patient's sticker

Version 11/16

Consent Form For

Arthroscopy of the Shoulder

Arthroscopy of the shoulder is an operation carried out in order to diagnose and/or surgically treat damage or injury due to traumatic injury, illness, or degenerative conditions. In addition this operation may be used to remove material and tissue from the joint for various laboratory tests. During the operation, several instruments are inserted to the joint through small holes (5-10 mm) in the skin. The instruments include optical equipment that allows displaying and photographing the examined area and instruments that allow performing operations in the joint, such as: Drilling of tiny channels, making tiny stitches, planting tiny anchors, grinding and resection of bone spurs, resection of damaged tissues, and extracting tissues for laboratory testing.
These operations are usually carried out under general or local anesthesia.

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

on the need for arthroscopic of the right/left shoulder for the purpose of:

hereinafter: the Primary Surgery.

I was also explained about the treatment alternatives for treating my condition.

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I hereby declare and confirm that I was informed of the side effects of the primary surgery, including: Pain and discomfort, swelling of the shoulder joint and limited range of motion in the shoulder. There will, usually, also be a need for physiotherapy rehabilitation during the postoperative period and at times there will be a need for fixing the limb in a brace for several weeks.

I have been explained the possible risks and complications including: Contamination, damage to blood vessels, motor or sensory nerve injury, external arm skin sensation damage, shoulder bone, collarbone and arm bone fractures, torn ligaments, cartilage damage or damage to other tissues in and around the shoulder joint, joint injury resulting from the surgical tools themselves,
CRPS - Complex Regional Pain Syndrome, blood clots in the deep veins of the limb, pulmonary embolism, pneumothorax. These complications are rare. I have been informed that additional surgical procedures might be necessary to correct these complications and that it is possible that permanent damage might remain which could not be repaired.
I have been informed that after surgery for the repair and stitching of a tear or a surgery for the repair and stitching of tendon rupture, there is a risk for the recurrence of the tear, which might require repeated surgery. I have been informed that it may be necessary to expand the scope of the surgery to open approach by means of arthrotomy (shoulder joint opening with a larger section) to treat injury or damage that cannot be treated with arthroscopy only.
I hereby declare and confirm that I have been informed and that I understand that there is a possibility that during the primary surgery it will become necessary to extend its scope, change it or take other or additional procedures to save lives or to prevent physical damage, including additional surgical operations that can not be currently foreseen with certainty or in full, yet their implication was explained to me. Therefore I also agree to such an extension, modification or performance of different or additional procedures.
It has been explained to me that if the surgery is done under general anesthesia, an explanation concerning the anesthesia will be presented to me by an anesthesiologist.
If the surgery is performed under local anesthesia, I also consent to performing local anesthesia with or without intravenous injection of sedatives after I have been informed of the risks and complications of local anesthesia, including an allergic reaction to varying degrees of anesthesia and possible complications of using sedatives, which might rarely cause respiratory disorders and heart arrhythmia, especially in patients with heart disease and patients with respiratory disorders.
I know that if the medical center has a university branch, student may take part in the course of the primary surgery, under full supervision.

I know and agree that the primary surgery and all the primary procedures will be performed by whoever is assigned to conduct them according to the procedures and instructions of the Medical Center, and that I have not been promised that they will be done, neither in whole nor in part, by a certain specific person, provided they are conducted with the acceptable responsibility and subject to the law.

כללית מעל 100 שנה
הכי טובה למשפחה

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I hereby grant my consent to perform the primary surgery.

Date	Time	Patient Signature

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

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