Space for Medical Institution Name and Logo

ט 0130/8370/SURG/ORTHO/ יולי 1999

טופס הסכמה: ניתוח לתיקון גף עוותי-ספסטי

CONSENT FORM: CORRECTION OF SPASTIC LIMB

The purpose of the spastic limb correction surgery is to improve the joint's / limb's range of motion and/or the limb's axis in cases where a neurological disorder has caused shortening of muscles, deviation of the limb axis and limitation of joint motion. The operation includes releasing, lengthening or transferring of muscles and/or tendons. The operation is usually one of the stages performed to achieve functional improvement.

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

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
regarding **the operation for correction of spastic limb(s) and/or joint(s)**
_____
Note limb(s) and areas of correction
(henceforth: "the primary operation").

I have been told that the operation does not treat the basic problem, and that the functional disorder may recur, at varying degrees, in which case additional treatments will be necessary, including surgery. In addition, I have been told of the possibility that the desired outcome will not be achieved, or that the repair will be partial, and additional treatments will be necessary, including surgery to improve function.

I hereby declare and confirm that I have been given an explanation concerning the alternative surgical options, and the advantages and disadvantages of each of these.

I have been given an explanation concerning the expected side effects following the primary operation, including: pain and discomfort, as well as temporary limitation of motion, which may even cause a functional disorder.

I hereby declare and confirm that I have been given an explanation concerning the possible risks and complications of the operation, including: infection that may even require surgical intervention; prolonged weakness of the lengthened muscles; and in rare cases, damage to blood vessels and nerves.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures, may arise, in order to save my life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time but whose significance has been made clear to me. I, therefore, also give my consent to such an extension, modification or performance of different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary operation.

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I hereby also give my consent to the administration of local anesthesia, after the possible risks and complications of local anesthesia have been clarified, including various degrees pf allergic reactions to the anesthetic drug.

If the decision is made to perform the primary operation under general or regional anesthesia, I will be given an explanation regarding the anesthesia by an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated person, according to the hospital's procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

_____	_____	_____
Date	Time	Patient Signature

_____	_____
Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has 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.

* Cross out irrelevant option, and circle planned option.