Consent form

Mastoidectomy

The mastoid bone is a bony projection behind the ear, containing many air cavities connected to the middle ear cavity. The procedure is intended to remove and drain chronic infections or cystic lumps (cholesteatoma) and sometimes to treat acute infections that reach the mastoid bone. Less frequent indications for the surgery are tumor removal or treatment of Meniere's Disease. In some cases, a series of procedures is required to remove the disease entirely. There are situations where the procedure is accompanied by surgery in the middle ear and eardrum. Removal of infection/cholesteatoma/tumor from the mastoid allows to perform a hearing restoration surgery. The extent of surgery, type of procedure and possible filling of the operated mastoid cavity will be determined by the surgeon based on the scope of the disease and other professional considerations.
Surgery is carried out under 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 mastoidectomy due to _____

_____

_____ (hereinafter: "the procedure")

I was informed that in some cases a repeated procedure may have to be considered due to recurrence of the initial disease or chronic secretions. More than one procedure may have been designated to begin with. When the mastoid cavity remains open after surgery, the ear canal opening may have to be extended.

I was informed a scar will remain after surgery. The shape of the scar depends on my skin type and its healing properties and in some cases keloid scars may develop (thick, protruding scars). Sometimes the position of the auricle may change.

I hereby declare and confirm I received an explanation of the side effects of the procedure, including: earaches, secretions from the ear, decreased sensation in the operated area, pain when chewing, possible modification of sense of taste.

Furthermore, I received an explanation of the possible risks and complications of the procedure, including: bleeding, infection, tinnitus (buzzing in the ear), dizziness due to damage to inner ear, temporary or permanent paralysis of the facial nerve, worsened hearing deficiency, deafness, rupture of brain membranes and leak of spinal liquid, meningitis, brain abscess, massive bleeding due to damage to a large blood vessel.

I hereby provide 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 was informed that the procedure will be performed under general anesthesia, and the anesthetist will give me a relevant explanation about it.

I am aware of 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.**

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

החברה לניהול סיכונים ברפואה בע"מ