Consent form

Neck Dissection

Neck dissection is carried out in order to remove tumors and/or as continuation and completion of malignancy removal procedures or procedures to remove and prevent metastases in the head and neck. The scope of the procedure and the operated side/s are determined by the size and location of the metastases and/or primary tumor.
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 surgery on the _____ side due to _____

_____

_____ (hereinafter: "the procedure")

I was informed that in some cases the tumor may not be removed entirely due to anatomical reasons (size and depth of tumor). I was informed neck tumor or metastases may recur.

I hereby declare and confirm I received an explanation of the side effects of the procedure, including: aches and discomfort, decrease in sensation of the neck and facial skin, usually temporary.

Furthermore, I received an explanation of the possible risks and complications of the procedure, including: infection, bleeding that could be life threatening, weakness or restricted mobilityof the shoulder, limited mobility of the arm, paralysis of the diaphragm, difficulty moving the tongue and, in some cases, metallic taste, damage to facial muscles, loss or disruption of voice, difficulty swallowing, perforation of the pharynx, the esophagus, the trachea or the lung, need for intubation (tracheostomy), leakage of saliva or lymphatic liquid (fistula), swollen face, damaged eyesight and/or brain damage due to injury of the carotid artery. In rare cases the procedure may end in death.

The procedure involves deformation and asymmetry of the two sides of the neck. Skin necrosis may occur, sometimes an implant, skin or tissue graft may be needed for reconstruction purposes. I was also informed that following the procedure I may suffer from restricted mobility of the head and neck due to removal of muscular mass.

I was told that in any case a scar will remain on my neck. 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).

כללית מעל 100 שנה
הכי טובה למשפחה

I hereby provide my consent to performance 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 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 was told the procedure would be carried out under general anesthesia and I would receive an explanation of the anesthesia from the anesthetist.

I also provide my consent to performance of local anesthesia with or without intravenous injection of sedatives after having received an explanation of the risks and complications of local anesthesia including various degrees of allergic reaction to anesthetics, and possible complications of the use of sedatives that could, in rare cases, cause disrupted breathing and action of the heart, particularly among cardiac patients or those suffering from respiratory system problems.

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.**