כללית מעל 100 שנה
הכי טובה למשפחה

Consent form

Sialoendoscopy

Sialoendoscopy is a procedure that involves inserting a very thin optic fiber through the mouth into the parotid gland drain duct or that of the sub-mandibular salivary gland. The surgeon may also insert additional devices in order to treat the problem, e.g.: blockage, narrowing of the salivary gland drain ducts, biopsy of a tumor or suspected tumor, cleansing of the gland to remove stones and dense secretions that block it, etc. In some cases a contrasting substance is injected and x-rays are made. Sometimes a small external incision is made to the facial skin or under the jaw. Endoscopic access may replace open surgery. Surgery is carried out under local or general anesthesia. You must inform your physician if you are allergic to local anesthetics or the contrasting substance.

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

Regarding the need for sialoendoscopy _____ on the _____ side

Due to _____ (hereinafter: "the procedure")

In case the removal of stone or opening the blockage does not succeed, or the condition becomes worse, future surgery may be required to remove the diseased gland. In some cases external stone shattering is required.

I hereby declare and confirm that I received an explanation about the side effects of the procedure, including pain and discomfort and temporary swelling of the gland.

Furthermore, I received an explanation of the possible risks and complications of the procedure, including: infection of the gland, lengthy discomfort, damaged teeth, changed sense of taste, bleeding, difficulty in moving the tongue, perforation of the salivary duct, unplanned bursting into facial or throat skin causing salivary leakage, damage to a section of the facial nerve to the point of partial paralysis of facial movement, scarring of the salivary duct that worsens the problem, allergic reaction to injected substance.

I hereby give 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 am also providing my consent to local anesthetics with or without intravenous injection of sedatives, after having received an explanation about the risks and complications of local anesthetics including various degrees of allergic reaction to the sedatives and possible complications due to the use of sedatives that may, rarely, cause respiratory disorders or cardiac disorders, particularly among cardiac patients and those with respiratory system disorders.

I was informed that should the procedure be performed under general anesthesia the anesthetist would give me a relevant explanation about it.

I am aware that 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.

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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