טופס הסכמה:ניתוח כריתת שקדים/אדנואידים

CONSENT FORM: ADENOIDECTOMY/TONSILLECTOMY

The operation of excision of the adenoids/tonsils is usually carried out for breathing difficulties and/or recurrent and/or chronic infections, sometimes as a means of preventing complications, and/or disturbances of the middle ear, and/or speech disturbances, and/or defects in development of the facial bones.

Name of Patient: _____ _____ _____ _____

Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:

Dr. _____ _____

Last Name First Name

regarding the need for excision of the tonsils/adenoids because of_____
_____ (henceforth: "the primary operation").

It has been explained to me that there are cases in which there will be a need for a repeat operation because of regrowth of the adenoids.

I hereby declare and confirm that I have received an explanation regarding the side effects of the primary operation including pain, discomfort, and difficulty in swallowing.

I have also received an explanation concerning the possible risks and complications of the operation including: immediate or later bleeding that may require returning to the operating theatre to stop the bleeding; infection, difficulty in swallowing to the extent of requiring hospitalization because of the need for intravenous fluids, damage to the teeth, lips, gums, and tongue and also speech disturbance including nasal speech that, if it does not improve, may require an operation for its correction. In rare cases, there may be scarring in the region of the operation, which is liable to cause narrowing of the region of the pharynx and/or the eustachian tube that connects with the middle ear, accompanied by disturbed function.

The operation is associated with mortality in very rare cases.

I hereby give my consent to perform the primary operation.

In addition, I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need to extend or modify the operation, or 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.

It has been explained to me that the operation is performed under general anesthesia and I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know, confirm and agree that the primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

תמצית ההסבר שניתן למטופל:

_____
_____
_____
_____
_____
הערות:_____
_____

הערת הסכמה מקום שיחת ההסכמה_____

נוכחים בשיחה: _____

תאריך שעה חתימת המטופל

Date Time Patient Signature

_____ _____ _____

שם האפוטרופוס חתימת האפוטרופוס (במקרה של פסול דין ,קטין או חולה נפש)

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

_____ _____

אני מאשר כי הסברתי בעל פה למטופל / לאפוטרופסו של המטופל את כל האמור לעיל בפירוט הדרוש וכי הוא חתם על הסכמה בפני ,לאחר ששוכנעתי כי הבין את הסברי במלואם.

_____ _____

שם הרופא וחתימה מס' רשיון