כללית

טופס הסכמה: הפסקה סלקטיבית של ההריון
CONSENT FORM: SELECTIVE TERMINATION OF PREGNANCY

A selective termination of a pregnancy involves the insertion of a needle through the abdominal wall and the injection of a concentrated saline solution into the heart of a fetus that has been diagnosed as defective, in order to put it to death. The deceased fetus usually remains in the uterus until delivery.

Name of Woman: _____ _____ _____ _____
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
that an obstetrical U.S. / other test revealed _____.

For reasons that were explained to me, the diagnosis cannot be absolutely confirmed or ruled out. I have been given an explanation that although the findings were observed with high certainty, there is a possibility of a mistaken diagnosis due to the limitations of the test.

Based on these findings, I have expressed my absolute desire to terminate the pregnancy of the defective fetus (hereinafter: "the primary procedure").

I hereby declare and confirm that I have been given an explanation concerning the course of the primary procedure and the possible side effects, including pain and discomfort.

In addition, I have been given an explanation concerning the risks and complications associated with the said procedure for me / the woman and for the healthy fetus(es). I have been given an explanation that the risks for the healthy fetus(es) include, amongst others, the possibility of premature delivery, the possibility of formation of emboli, brain damage or other injuries that cannot be predicted in advance, and even death in rare cases.

I have been given an explanation that the risks for me / the women include, amongst others, the possibility of infection, hemorrhage and in rare cases, blood clotting disorders that my endanger my life. It has been clarified that injuries caused to me / the women may also affect the healthy fetus(es).

I hereby give my consent to perform the primary procedure.

I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary procedure the need to extend or modify the operation or to perform additional or different procedures may arise in order to save my / the woman's 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 procedure.

I hereby also give my consent to the administration of local anesthesia, at the physicians' discretion, after having been given an explanation concerning the possible complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug. If the decision is made to perform the operation

under general or regional anesthesia, I will be given an explanation concerning the anesthesia by an anesthesiologist.

I know and agree that the primary procedure and any other procedure will be performed by any designated physician, according to the institutional 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 / 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.