טופס הסכמה: הפסקת הריון בשליש הראשון של ההריון

CONSENT FORM: VACUUM/CURETTAGE OF UTERUS FOR TERMINATION OF PREGNANCY (D & C)

Termination of pregnancy is performed by dilating the cervix of the uterus and separating the fetus and the placenta from the wall of the uterus by suction and curettage.
The procedure is carried out under general anesthesia.

Name of Woman: ______________ ______________ ______________ ______________
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 termination of pregnancy (henceforth: "the primary procedure").

I declare and confirm that I have received an explanation regarding the side effects after the primary procedure including abdominal pain and mild bleeding that will cease spontaneously within a few days. I have also received an explanation concerning the possible risks and complications, including the possibility of perforation of the uterus and the need for an immediate operation, and the possibility of immediate or later infection.
I have also had the possible late complications explained to me including menstrual disturbances, extra-uterine pregnancy, cervical incompetence and as a result recurrent miscarriages and/or premature births, which may require stitching the cervix of the uterus during pregnancy in the future. There is also the possibility of difficulty in attachment of the placenta and/or infections that are liable to interfere with the ability to become pregnant in the future.
I have received an explanation reading the importance of a follow-up visit two weeks after the primary procedure to ensure that the pregnancy was terminated as expected.
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 procedure the need to extend or modify it, 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 procedure.

I have been told that the primary procedure is performed under general anesthesia and that I will receive an explanation regarding the anesthesia from an anesthesiologist.

The procedure may also be carried out under local anesthesia after the possible complications of local anesthesia have been explained to me, including disturbances of heart rhythm, a fall in blood pressure and allergic reactions of varying degree to the anesthetic substances.

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.

____________________	____________________	____________________
Date	Time	Patient's Signature

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

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

____________________	____________________	____________________
Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.