טופס הסכמה: ניתוח דלף מחדרי המוח

CONSENT FORM: EXTRACRANIAL VENTRICULAR SHUNT

The brain consists of 4 cavities, named ventricles, which contain the cerebrospinal fluid. The fluid is produced in the ventricles, and then cleared away into the blood circulation. When the flow of fluid is blocked, the pressure in the ventricles rises, and the ventricles expand at the expense of the brain tissue. This condition is termed hydrocephalus.

The purpose of the shunt is to bypass the obstruction and transfer the fluids into the peritoneal cavity in the abdomen, or to the pleural cavity in the chest, or to the heart, where it is absorbed into the circulation.

Without treatment, there is danger of irreversible brain damage and even death. The shunt consists of a ventricular tube, inserted into the head through a small hole in the skull, and an additional tube that is passed under the skin of the neck and chest and inserted into the abdominal cavity, or the chest cavity, or the heart. The tube is inserted into the heart cavity through a small incision in the neck vein, under imaging, following the injection of contrast medium. Connecting the two tubes is a valve, shaped like a button, which is usually placed under the scalp at the back of the neck, and can be palpated. The flow of cerebrospinal fluid through the shunt is unidirectional, from the brain to the abdomen or chest or heart, and thus, pressing this valve enables demonstration of the shunt's function.

The operation is performed under general anesthesia. In children, the abdominal tube must be lengthened after a few years.

Name of Patient: _____ _____ _____ _____
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
regarding the need for surgery to insert a shunt from the cerebral ventricles into **the abdominal cavity / chest cavity / heart *** (henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation concerning the alternative treatment options under these circumstances, their side effects, and the risks and complications involved in each of these procedures.

I hereby declare and confirm that I have been given an explanation concerning the expected results of the primary operation, and the expected side effects, including: pain in the area of the incisions and along the route of the tube, nausea, vomiting and abdominal pain, which will gradually subside.

In addition, I have been given an explanation concerning the possible complications, including: bleeding from the surgical wounds; infection of the shunt; dysfunction of the shunt a short period of time after its insertion (due to reduction in ventricle size); infrequently, temporary paralysis of the bowel movements; inaccurate positioning of the ventricular tube, requiring additional repair surgery; cerebral hemorrhage where the ventricular tube is inserted. In rare cases, there may be leakage of cerebrospinal fluid surrounding the tube and valve in the scalp. In cases where the shunt is inserted into the peritoneal cavity, perforation of an abdominal organ may rarely occur during insertion of the tube into the peritoneal cavity.

In cases where the shunt is inserted into the pleural cavity, pneumothorax may develop, requiring drainage with an intra-costal drain. In rare cases, there is a possibility of death as a result of these complications.

In addition, it has been clarified that in cases where the shunt tube leads to the heart, if a bacterial infection develops in the blood in the future, it will be necessary to remove the shunt. Furthermore, preventive antibiotic treatment will be required prior to any dental procedure or operation.

I have been told that during the primary operation, the need may arise to expand the operation, connect an additional tube, or change the planned course of the shunt.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary operation, or immediately following it, the need to extend or modify the operation or to 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 or immediately following it.

I have been told that the primary operation is performed under general anesthesia, and that I will be given an explanation regarding the anesthesia by an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated person, 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 / the 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.