טופס הסכמה: ניתוח רביזיה של דלף מוחי

CONSENT FORM: REVISION OF EXTRACRANIAL VENTRICULAR SHUNT

The purpose of the shunt system is to bypass an obstruction to the flow of cerebrospinal fluid, and transfer the fluid to another body cavity (the peritoneal cavity in the abdomen or the pleural cavity of the lungs or the heart cavity). The shunt system consists of three parts: a cerebral ventricular tube connected to a unidirectional valve in the scalp, and an additional tube from the valve to the final cavity. An impairment in the function of the system is caused by the obstruction of one of its parts, disconnection of the parts or "shortening" of the tubing due to growth of the body.

If the tubes are obstructed or disconnect, revision surgery is necessary to repair the defect. The operation involves incisions made on or near the scars from the previous operation, along the tubes, in the head and/or neck and/or chest and/or abdomen. The existing tubes can remain in place or be replaced with new tubes.

If the tube is too short, it can be lengthened by connecting an additional part. One week of hospitalization is expected.

The operation is performed under general anesthesia.

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 a revision of the extracranial shunt (henceforth: "the primary operation").

I hereby declare and confirm that I have been told that there are no alternative methods to treat a dysfunctional shunt system. I have been told that in certain cases the need for an operation may be slightly postponed (but not canceled), using medicines that increase the urinary output, and steroids. It has also been clarified that repeated lumber punctures, or prolonged external drainage, are only temporary solutions, and they do not replace the need for surgery, and involve a significant risk of infection.

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 incisions, nausea and/or vomiting, which will gradually subside. It has been clarified that possible infrequent complications include: infection and hemorrhage in the cerebral ventricles, and in rare cases, perforation of the intestines, and leakage of cerebrospinal fluid around the shunt tubes or from the surgical wounds, requiring additional repair surgery. In very rare cases, there is a possibility of death as a result of these complications.

I have been told that during the primary operation, the need may arise to leave parts of the existing tubes and insert new parts, or insert a completely new shunt system into the brain, abdominal cavity, pleural membranes or heart cavity.

In addition, I have been told that in cases of insertion of a tube into the heart cavity, contrast medium may be injected into the tube to allow proper positioning.

I hereby give my consent to perform the primary operation.

In addition, 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.