טופס הסכמה: ניתוח הסרת פטריגיום

CONSENT FORM: PTERYGIUM REMOVAL

Pterygium is growth of the conjunctiva over the cornea whereas in the normal eye the conjunctival tissue ends at the border between the white of the eye and the cornea. During the operation the tissue of the pterygium is removed from the surface of the cornea and the site from which the pterygium grew over the white of the eye is treated surgically and/or with medication. In certain cases, at the discretion of the physician, treatment with an antimetabolic substance or local radiation is given to prevent recurrent growth of the pterygium. In rarer cases, especially after recurrence of the pterygium after a previous operation, conjunctival or corneal transplant is performed.
The timing of the operation and method of operation are decided on depending on the size of the pterygium, the age of the patient, the state of the conjunctiva and the position of the eyelid. The pterygium tends to recur especially at a young age and the rate of recurrence decreases with age (the literature reports a recurrence rate of 50%). There is no alternative to surgical treatment for pterygium. There is a possibility of not operating when the pterygium is inactive, does not affect sight and does not disturb the patient esthetically. The operation is carried out under local anesthesia.

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 pterygium removal from the left/right* eye (henceforth: "the primary operation").

I hereby declare and confirm that I received an explanation concerning the expected results including the possibility of recurrence of the pterygium. The side effects including pain, discomfort, bleeding into the conjunctiva and eyelids that usually resolve in a short time, were explained to me.
I also received an explanation concerning the possible risks and complications, including: infection, changes in refraction, double vision, development of adhesions between the eyelid and eyeball (symblepharon), which may cause limitation in movement of the eye and double vision or retraction of the eyelid and watering of the eye.

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.
I also consent to the performance of local anesthesia, after I have received an explanation regarding the risks and complications of local anesthesia including bleeding, infection, injury to the eye and in rare cases loss of vision.

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.