טופס הסכמה: ניתוח לכריתת זגוגית עם/בלי טיפול בהיפרדות רשתית
CONSENT FORM: VITRECTOMY WITH/WITHOUT REPAIR OF RETINAL DETACHMENT

An operation for excision of the vitreous humor is performed to enable the passage of light to the retina in cases in which the vitreous becomes opaque due to diseases such as diabetes or bleeding into the eye. During the operation the vitreous tissue is replaced by suitable material.
There are many cases in which damage to the vitreous is accompanied by damage to the retina. Retinal detachment is a condition in which the retina separates from its position as a result of injury, eye diseases, or diseases such as diabetes and its ability to receive visual stimuli is impaired. In such cases an operation is carried out to with the purpose of attaching the retina in place by different methods together with removal of the vitreous and injection of special material into the eye to replace the vitreous.
The operation is usually carried out under local or general 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 performing an operation for removal of the vitreous in the left/right* eye with/ without* an operation to repair retinal detachment (henceforth: "the primary operation").
I declare and confirm that it has been explained to me that there are no alternative options for the treatment of the condition.
I received an explanation concerning the expected results, including the possibility that if the operation is performed also for retinal detachment, there will be a need in some of the cases for additional operation(s) in order to restore the retina to its place.
I hereby declare and confirm that I have received an explanation regarding the side effects after the operation including: pain, discomfort, redness and swelling.
I also received an explanation concerning the possible complications including: infection, bleeding, changes in refraction that will require wearing glasses or change of previous glasses, drooping of the eyelid, double vision, retinal tears, retinal detachment, lens damage or even total loss of vision in the eye and shrinkage of the eyeball. If the operation includes repair of retinal detachment, complications such as squint, increase in intraocular pressure and accelerated development of cataract are possible.
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 the risks and complications of local anesthesia have been explained to me, including: bleeding, infection, harm to the eye and in rare cases loss of vision.
If it is decided to perform the operation under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.

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Medical Risk Management Co.

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 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 Signature	License No.

* Cross out irrelevant option.