מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:
שם משפחה: שם פרטי:
שם האב: תאריך לידה:
כתובת:
טלפון:

מדבקת פרטי מטופל

טופס הסכמה: ניתוח לתיקון הפרעה התפתחותית של מפרק הירך
CONSENT FORM: CORRECTION OF DEVELOPMENTAL DYSPLASIA OF THE HIP (DDH)

Surgery for correction of developmental dysplasia of the hip is performed when the joint cannot be reconstructed by any other method.

The operation is performed to prevent shortening of the limb, limitation of motion, pain and premature degenerative changes. Following surgery, the joint must be fixated for a number of weeks.

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 operation for correction of **the right / left * hip joint** (henceforth: "the primary operation").

I have been told that in certain cases the desired outcome is not achieved, or only partial repair is achieved, and additional surgery may be necessary.

I hereby declare and confirm that I have been given an explanation concerning the alternative surgical options, and the advantages and disadvantages of each of these.

I have been given an explanation concerning the expected side effects following the primary operation, including: pain, discomfort and limitation of motion

I hereby declare and confirm that I have been given an explanation concerning the possible risks and complications, including: infection that may even require surgical intervention; damage to the blood supply to the head of the femur, which may harm the development of the head of the femur and require surgery for repair. In rare cases, during the operation, damage may be caused to blood vessels or nerves, leading to a functional disorder.

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 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.

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.

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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, and circle planned option.