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 להחלפה של מפרק הירך או הברך
Consent Form: Total Hip/Knee Replacement

Replacement of the hip or knee joint by an artificial prosthesis is performed in cases of severe damage to components of the joint for different reasons. During the operation the joint surfaces are replaced by a prosthesis made from plastic, ceramic and metallic materials. The operation is performed under general and/or regional 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 nature of my disease and the need for performing an operation for replacement of the **left/right* knee/hip*** joint.
Type of prosthesis_____(henceforth: "the primary operation").

I know that the length of life of an artificial prosthesis is limited and the need may arise for repeat operations in the future.
I hereby declare and confirm that I received an explanation concerning the side effects after the primary operation, including: pain, discomfort, and limitation of movement.
I also received an explanation concerning the possible risks and complications of the primary operation, including: infection, which sometimes necessitates removal of the prosthesis by operation, leaving the joint without a prosthesis for different periods of time, and additional surgical intervention; loosening of the prosthesis that will warrant an additional operation; limping due to a difference in the length of the limbs, and/or nerve damage to the muscles of the limbs, and/or functional disturbance of the muscles; and also thromboembolic complications. In operations for hip replacement dislocation is also possible, which will warrant additional operations or prolonged lying in bed. These complications are not common.
I hereby declare that I received an explanation regarding the prosthesis that is intended for use in the operation but I understand that there is a possibility that in the course of the operation it may be necessary to change the type of prosthesis and/or the scope of the operation in view of difficulties that may arise in fixing the prosthesis to the bone or are related to the quality of the bone.
I hereby give my consent to perform the primary operation.
I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need may arise to extend it, change it, or to carry out other or additional interventions including additional surgical procedures to save life or avoid bodily harm, including additional surgical procedures that cannot be predicted h cannot be fully or definitely predicted at the time with certainty or in full, but whose significance has been made clear to me. I, therefore, also give my consent to such an extension, modification or performance of other or additional procedures including operations, 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 and/or regional anesthesia and that I will receive an explanation regarding the anesthesia from an anesthesiologist.

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.

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

Date Time Patient Signature

Name of Guardian (Relationship) Guardian 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 and circle the relevant option .