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 עפעפיים

CONSENT FORM: BLEPHORAPLASTY

The purpose of the operation is to remove excess skin and adipose tissue from the eyelids. The operation does not remove wrinkles from the sides of the eyes. The operation can be performed as part of a facelift operation.

The operation is usually conducted following the administration of local anesthesia and sedatives.

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 surgery of the **upper eyelid / lower eyelid / both eyelids* of the right / left / both eyes*** (henceforth: "the primary operation").

I have been told that in my case the eyelid **must / must not** * be **stretched sideways or upwards**.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: pain, discomfort, swelling of the eyelids; dryness in the conjunctiva or tearing; subcutaneous hemorrhages around the eyes, redness in the eyes and an itching sensation. The scars will be apparent for several weeks and will then become much less distinct.

In addition, I have been given an explanation concerning the possible complications, including: infection, the occurrence of cysts in the suture area, prominent scars, alteration in the form of the eye opening, tugging of the eyelid, damage to the lacrimal gland causing dehydration of the conjunctiva or tearing, chronic pain in the operated area, temporary or permanent loss of eyelashes, asymmetry between both sides of eye, and in rare cases, hemorrhage necessitating emergency surgery.

I hereby give my consent to perform the primary operation.

I hereby also give my consent to the administration of local anesthesia, with or without intravenous injection of sedatives, after having been given an explanation concerning the risks and complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possible reactions to sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with heart disease and respiratory disorders.

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טלפון:

מדבקת פרטי מטופל

I know and agree that the 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, and that the person in charge of the operation will be ** _____.
Name of Physician

_____ _____ _____
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.
** Complete for private patients.