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: טיפול בסדק בפי הטבעת

CONSENT FORM: REPAIR OF ANAL FISSURE

The aim of the treatment is to decrease the strength of the contraction of the anal sphincters so as to lessen the pain and allow healing of the fissure/lesion in the anal mucosa. The intensity of the anal sphincter contraction can be decreased in two ways: one is by manual stretching of the sphincter muscle and the second is by surgically incising the muscle of the internal sphincter. The decision as to which treatment should be used is based on medical judgment and depends on the findings.
The treatment is usually carried out under general or regional anesthesia, but sometimes 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
concerning the surgery/treatment of the anal fissure – Anal dilatation/lateral sphincterotomy/other* -details:

_____(herewith "main procedure".
The advantages, disadvantages and appropriateness for my situation of other forms of treatment have explained to me.
Similarly, it has been explained to me that there is no absolute certainty that the main procedure will solve the problem, and that sometimes other treatments/ may be necessary.
I hereby declare and confirm that I have received an explanation regarding the risks and possible complications, including: bleeding, infection with the development of an abscess and the possibility of the appearance of a fistula that, in some cases, will require further surgery. There is also the risk of damage to the anal sphincters, which may result in loss of control of flatus and staining of my undergarments with mucus/stool or even complete loss of bowel control. Most of these situations are likely to resolve spontaneously with a few months, or after carrying out anal sphincter and pelvic floor muscle training exercises. In rare cases there may be permanent damage to the sphincters.
I give my consent to the main procedure.
I also declare and confirm that it has been explained to me, and I understand, that there is a possibility that in the course of the main procedure it will become apparent that there it becomes necessary to increase the extent of the procedure, to change it or to carry out additional surgical procedures, or unforeseen procedures other than the planned procedure. This situation may arise as a result of findings that come to light during the examination under anesthetic (especially when it had not been possible to perform the appropriate examination before the surgery because of the anal pain). I therefore consent to such aforesaid extension of the procedure, to a change or to other or additional procedures, including surgical procedures that in the opinion of the institutions' doctors are essential or necessary in the course of the main procedure.
It has been explained to me that the main procedure will be carried out under regional or general anesthesia, and an anesthesiologist has provided me with an explanation regarding the anesthesia.
I hereby also consent to the use of local anesthesia, should it be decided to carry out the main procedure under local anesthesia, after having received an explanation of the possible complications of local anesthesia, including various degrees of allergic reactions to the anesthetic materials.
I hereby consent to undergoing the main procedure.

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* Delete whichever is inappropriate

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מדבקת פרטי מטופל

I am aware, and agree that the main procedure and all the other procedures will be carried out by whomever is allocated the task, in accordance with the instructions and demands of the institution, and that I have not been guaranteed that all or part of the procedure will be carried by a specific person; with the understanding that it will be carried out under the accepted responsibility of the institution in accordance with the law, and the person with overall responsibility for main procedure 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 provided the patient / the patient's guardian** with a detailed verbal explanation of all the above mentioned, 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.

*Fill in, in the case of a private physician ** Delete whichever is inappropriate.