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 לכריתת התוספתן
CONSENT FORM: APPENDECTOMY

Complaints and clinical findings that raise the suspicion of an acute inflammation of the appendix require its surgical removal. The presence of an inflamed appendix in the abdomen causes a life threatening focused or diffuse intra-abdominal infection. At times, during the operation, a complicated inflammatory condition is discovered, preventing the removal of the appendix. In such cases a drain is inserted and a second operation is required at a later date. If the appendix is found not to be inflamed, the abdomen is surveyed to locate and identify a reason for the complaints and clinical findings, and the surgical treatment is determined accordingly. In these cases, the removal of the appendix is at the surgeon's discretion.

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 need for an appendectomy (henceforth: "the primary operation").

I have been given an explanation concerning the possibility that the appendix will be found not to be inflamed but will nonetheless be removed.

I hereby declare and confirm that I have been given an explanation concerning the expected side effects following the primary operation, including pain and discomfort

In addition, I have been given an explanation concerning the possible complications, including: infection, hemorrhage, damage to abdominal organs, adhesions that may cause mechanical sterility in women.

I hereby give my consent to perform the primary operation.

In addition, 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 receive an explanation regarding the anesthesia from an anesthesiologist.

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שם האב:	תאריך לידה:
כתובת:	
טלפון:	**מדבקת פרטי מטופל**

I know and agree that the primary operation and any other procedure will be performed by any designated physician, 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 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.