



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

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

## אורטרוסקופיה CONSENT FORM: URETEROSCOPY

An ureteroscope is a rigid or flexible device, equipped with a telescope, through which the upper urinary tract can be explored and various instruments can be introduced, such as forceps, balloon catheters or baskets, and various types of lithotripters, for the diagnosis and treatment of tumors, stones, stricture and more. The device is inserted through the urethra, under local, regional or general anesthesia. When the ureteroscopy is completed, an internal catheter is usually inserted into the ureter, between the kidney and the urinary bladder, to allow drainage of the kidney until the edema caused by the procedure subsides.

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 a **diagnostic and/or therapeutic ureteroscopy\***. Detail options for planned treatment: \_\_\_\_\_

(henceforth: "the primary treatment").

I have been given an explanation concerning the possible diagnostic alternatives in my circumstances, and the benefits and risks involved in each.

I hereby declare and confirm that I have been given an explanation concerning the side effects of the primary treatment, including pain and discomfort in the waist and lower abdomen, frequency, urgency and a burning sensation during urination, and bloody urine. These side effects are temporary and usually subside within 24 hours.

In addition, I have been given an explanation concerning the possible complications, including: infection accompanied by a fever; obstruction of the ureter due to edema or stone fragments; perforation of the ureter; late development of ureteral stricture and in rare cases, detachment of the ureter. These complications are usually resolved by the insertion of a catheter into the ureter for a period of ranging from a few days to a few weeks. Isolated cases require open surgery. The development of a ureteral stricture may necessitate an additional ureteroscopic treatment or open surgery, and in rare cases may end in removal of the kidney.

The treatment is relatively innovative and therefore, there may be complications that are currently unknown.

I hereby give my consent to perform the primary treatment.

In addition, I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary treatment, or immediately following it, the need to extend or modify the procedure 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





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**מדבקת פרטי מטופל**

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 hospital's physicians deem essential or necessary during the primary treatment or immediately following it.

I hereby also consent to the administration of local anesthesia, if required, at the physicians' discretion, after having been given an explanation concerning the possible complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug.

If the decision is made to perform the primary treatment under regional or general anesthesia, I will be given an explanation concerning the anesthesia by an anesthesiologist.

I know and agree that the primary treatment 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 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.