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: ביצוע מילה רפואית/כריתת ערלה (כירורגית)

# CONSENT FORM: CIRCUMCISION

Circumcision (excision of the foreskin) is usually performed for religious, traditional or social reasons. Sometimes the need arises for excision of the foreskin because of inflammation of the foreskin that may cause difficulties in passing urine.
It has been explained to me that circumcision may be performed by a mohel.
Circumcision/surgical excision of the foreskin is usually performed with local or regional (penile block) anesthesia and sometimes general anesthesia is necessary.

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 performance of surgical circumcision (hereafter: "the main operation") .
I declare and confirm that I have been given an explanation regarding the desired results and side effects to be expected after the main operation including pain and discomfort.
Also, the possible complications and risks have been explained to me, including: injury to the glans (head) of the penis, infection and torsion of the penis.

I hereby give my consent to performance of the main operation.

My consent is also given hereby to the performance of local or regional (penile block) anesthetic if the need arises for such, at the discretion of the physician after the possible complications of local anesthetic have been explained to me, including an allergic reaction of varying degrees to the anesthetic materials.

If it is decided to perform the main operation under general anesthetic, I will receive an explanation regarding the anesthesia from the anesthetist.

I know and agree that the operation and all the main operations and all other procedures will be carried out by whoever is designated to do so, according to the institutional procedures and directives of the institution and that it has not been promised to me that they will be carried out in whole or in part by a specific person, but only that they will be performed under the standard degree of responsibility of the institution, according to law.

_____ _____ _____
Date Time Patient Signature

_____ _____
Name of Guardian (Relationship) Guardian's 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.
* Cross out irrelevant option.

מחלקה כירורגית

ההסתדרות הרפואית בישראל
האיגוד האורתופדי בישראל
החברה הישראלית לכירורגיה של הברך ולארתרוסקופיה