מרכז רפואי ע"ש ברוך פדה, פוריה

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

טופס הסכמה: דיקור אבחנתי

CONSENT FORM: FINE NEEDLE ASPIRATION/NEEDLE BIOPSY/ CORE NEEDLE BIOPSY

Needle aspiration or biopsy is performed with the purpose of obtaining a sample of tissue or cells, in order to make a diagnosis, and/or assess the extent of changes/ degree of disease in the target organ and the extent of spread of the disease.
The procedure is carried out by using a needle intended for this purpose, sometimes under guidance of imaging.
With the aid of the needle, cells or tissue is withdrawn and sent for cytological or pathological examination and/or culture as necessary. In most cases the time required is short. In those cases in which not enough material for examination is obtained it may be necessary to repeat the procedure.
After consideration of the age of the patient and type of procedure, it may be decided to use 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
regarding the need for performing FINE NEEDLE ASPIRATION/ NEEDLE BIOPSY / CORE NEEDLE

BIOPSY* from_____(hereafter: the primary procedure).
Name of organ
I have received an explanation that during the procedure a sensation of discomfort and pain in the region of the needle puncture is to be expected. Sometimes local bleeding at the site of the puncture may occur.
I have also received an explanation concerning the possible risks and complications of the primary procedure, including: prolonged pain, infection at the site of the puncture and/or in the target organ, continued bleeding that in some cases may require hospitalization for observation. Infrequently the bleeding will require blood transfusion or an operation to stop the bleeding. Rarely, damage caused to adjacent organs will require treatment. In very rare cases, these complications may lead to death.
I hereby give my consent to perform the primary procedure.
In addition, I hereby declare and confirm that I received explanation and understand the possibility that during the primary procedure, the need to extend or modify it, or perform additional or different procedures, may arise, in order to save 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 procedure.
I hereby consent to the administration of local anesthesia after the possible risks have been explained to me including the possibility of an allergic reaction of varying degree to the anesthetic medication. If it will be decided to perform the primary procedure under general anesthesia, an explanation of the anesthesia will be given to me by an anesthesiologist.
I know, confirm and agree that the primary procedure and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no

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guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

Date	Time	Patient's 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 abovementioned, 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's Signature	License No.

* Delete irrelevant option.