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: דיקור אבחנתי של כליה

CONSENT FORM: KIDNEY BIOPSY/FINE NEEDLE ASPIRATION

The biopsy is performed to obtain a tissue sample or cells from the kidney in order to make a diagnosis and/or assess the extent of changes/degree of the disease/extent of progress of the disease and/or assess the treatment possibilities of the kidney disease.
The aspiration is carried out by using a specific needle for this purpose. The aspiration is generally performed under imaging guidance. With the help of the needle cells/tissue are aspirated and sent for cytological, pathological examination, and/or culture and/or other examinations as required. In most cases the duration of the procedure is short. There are cases in which it is not possible obtain enough tissue for examination and it will be necessary to repeat the procedure.
The operation is usually carried out under local anesthesia.

Name of Woman: _____ _____ _____ _____
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 to perform a diagnostic aspiration biopsy of the kidney (henceforth: "the examination").

It has been explained to me that during the examination a sensation of discomfort and pain in the region of the aspiration is to be expected. Sometimes local bleeding appears at the site of the aspiration through the skin, giving rise to a change in color and slight sensitivity. A common side effect after the examination is blood in the urine that is seen only with a microscope (microhematuria). This side effect usually disappears spontaneously within a short time without treatment.
I hereby declare and confirm that I have received an explanation regarding the possible risks and complications of the examination including: blood in the urine (macrohematuria), which usually disappears without treatment. The bleeding is rarely significant or prolonged and may warrant blood transfusion and in very rare cases invasive intervention under radiological guidance or surgical intervention. Mild bleeding near the kidney may occur (hematoma) not usually accompanied by clinical signs but there may be a slight decrease in the hemoglobin level. Still more rarely, as a result of the passage of the needle through subcutaneous fatty tissue and muscle, bleeding may occur into soft tissue (hematoma) expressing itself by pain and swelling in the loin. Rarely a hematoma becomes infected requiring antibiotic treatment and/or surgical drainage.
Very rarely there may be damage to a blood vessel external to the kidney that causes local dilatation of the wall of the blood vessel (aneurysm) that is liable to warrant surgical repair. There is a possibility of passage being formed between a small artery and vein inside the kidney (arteriovenous fistula). Usually there is no clinical significance to this and almost all of them close spontaneously with time. Rarely damage is caused to nearby organs that will require treatment and/or operation.
I hereby give my consent to perform the examination.
I also hereby declare and confirm that I received an explanation and understand the possibility that during the examination the need to extend or modify it, or 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 examination.

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מדבקת פרטי מטופל

I also consent to carrying out local anesthesia after I have had the possible risks explained to me including an allergic reaction of varying degrees to the anesthetic substances. If performance of the examination under general anesthesia is decided on, I will receive an explanation regarding the anesthesia from an anesthesiologist.
I know and agree that the examination 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 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.

* Cross out irrelevant option.