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: דילול (הפחתה) עוברים / סירוב לדילול (הפחתה) עוברים

CONSENT FORM: FETAL REDUCTION

Interruption of pregnancy of fetuses is performed by introduction of a needle into the wall of the uterus or of the vagina and injection of saline solution into the heart of the fetus in order to cease its function. The fetus remains in the uterus and is totally absorbed. In the case of a number of fetuses, the procedure is repeated for every fetus separately, sometimes over a period of days. The procedure is usually performed without anesthesia.

Name of Wife: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

Name of Husband: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I/we hereby declare and confirm that we received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
that according to the ultrasound_____* fetal sacs were observed. In view of these findings and in view of the risk of a pregnancy with multiple fetuses, as was explained to us, I/we have expressed our desire and agreed to the performance of fetal reduction from _____* to _____* (hereafter: "the primary procedure").

*Indicate in words and figures

I/we declare and confirm that I/we have received an explanation regarding the process and the possible side effects including pain and discomfort.
I/we declare and confirm that the risks and complications to the remaining fetuses and the woman associated with the said primary procedure have been explained to me/us. It has been explained to me/us that the risks to the remaining fetuses include, among others, the possibility of miscarriage (abortion) of the pregnancy as a whole, the possibility of rupture of the membranes, death of the fetus or additional fetuses, premature labor that may end in the birth of a premature infant with all the associated complications, such as motor, mental and nervous defects and prolonged hospitalization.
It has been explained to me/us that the risks to the woman include among others, the possibility of infection, bleeding, and in rare cases disturbances of blood clotting that are liable to produce a threat to life.
It is clear to me/us that harm that is caused to the woman may also have implications for the fetuses.
I/we hereby give my/our consent to the performance of the primary procedure.
I also declare and confirm that it has been explained to me and that I understand that there is a possibility that during the process of the primary procedure it may become necessary to undertake other or additional procedures 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 procedure.
I hereby consent also to the performance of local anesthesia, after the risks and complications of local anesthesia have been explained to me, including sensitivity in varying degrees to the anesthetic materials. If it is decided to carry out the primary procedure under general anesthetic an explanation will be given to me by an anesthesiologist.

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

I/we know and agree that the primary procedure and all other procedures will be performed by any designated surgeon, 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	Woman's Signature	Husband's Signature (in the case of a married woman)

I hereby confirm that I provided the woman with a detailed verbal explanation of all the abovementioned, as required, and that she signed the consent/refusal** form in my presence after I was convinced that she fully understood my explanations.

Physician's name	Physician's signature	License No.

*Indicate the number of fetuses clearly and legibly.
** Delete the irrelevant

I hereby declare and confirm that I received a detailed verbal explanation regarding fetal reduction and the significance of leaving _____* fetuses in the uterus including the risks of early or late miscarriage (abortion) and premature rupture of membranes that necessitates cessation of the pregnancy and the birth of premature infants. It has been explained to me and I understand that the risks of prematurity include, among others, motor, mental and nervous defects and prolonged hospitalization and that in pregnancy with multiple fetuses the rate of birth by cesarean section is high.

I/we hereby declare refusal of fetal reduction.

Date	Time	Woman's Signature	Husband's Signature (in the case of a married woman)

I confirm that I have explained all the above verbally in the necessary detail to the woman and her husband** regarding reduction and leaving fetuses in the uterus and that she/they signed a refusal form in my presence after I was convinced that she/they understood my explanation fully.

Physician's name	Physician's Signature	License No.

*Indicate the number of fetuses clearly and legibly
**Delete the irrelevant