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

טופס הסכמה: ניתוח קוסמטי של האוזניים

CONSENT FORM: OTOPLASTY

The purpose of this operation is the cosmetic repair of the outer ears, or other cosmetic repair.

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 cosmetic surgery of **the right ear / the left ear / both ears *. Detail nature of operation** ____ (henceforth: "the primary operation").

I have been given an explanation concerning the expected results and the limitations of the ability to make modifications through surgery, including asymmetry and/or the ear returning to its previous condition.

I hereby declare and confirm that I have been given an explanation concerning the side effects of the primary operation, including pain, discomfort and alteration in the sensation of the outer ear skin.

I have been told that the surgical incisions are performed in the anterior or posterior aspect of the skin of the outer ear and the cartilage of the outer ear itself, and in any case scars will remain in place of the surgical incisions. In cases where cartilage is removed from the outer ear, a skin fold may form in front of the ear. I have been told that the form of scarring depends on my skin type and its healing qualities, and that in some cases, keloid scars may develop.

In addition, I have been given an explanation concerning the possible risks and complications, including: infection which may even lead to loss of skin and/or cartilage; gaping of the incision margins; and lack of sensation in the skin of the outer ear.

I hereby give my consent to perform the primary operation.

I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures may arise, 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 surgery, which the institution's physicians deem essential or necessary during the primary operation.

I hereby also give my consent to the administration of local anesthesia, with or without intravenous injection of sedatives, after having been given an explanation concerning the risks and complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possible complications of sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with heart disease and respiratory disorders. If the decision is made to perform the primary operation under general anesthesia, I will be given an explanation regarding the anesthesia by an anesthesiologist.

מסי זהות:

שם משפחה: שם פרטי:

שם האב: תאריך לידה:

כתובת:

טלפון:

מדבקת פרטי מטופל

I know and agree that the operation and any other procedure will be performed by any designated person, 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, and that the person in charge of the operation will be ** ______________________________.

Name of Physician

________________	________________	________________
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, and circle planned option.

** Complete for private patients.