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: בדיקת אקו לב דרך הוושט
TRANSEOPHAGEAL ECHOCARDIOGRAM (TEE)

The test examines the structure of the heart and its function by using ultrasound waves. In order to get a more detailed picture of the heart than in an ordinary echo a flexible tube about 1 cm in diameter is introduced into the stomach by way of the esophagus (endoscope), at the end of which there is a transmitter. The examination is carried out after local anesthesia of the throat by means of a spray, and usually also partial anesthesia, by giving a sedative medication through a vein. The examination is carried out with the patient lying down on the left side, and the duration of the test is usually 10-20 minutes.

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 process of the transesophageal echocardiogram test (hereafter: "the main examination").

I declare and confirm that the side effects of the main examination have been explained to me, including nausea, transient cough or slight pain in the throat after the examination.
Also, the risk of the examination, bleeding from or a tear of the esophagus, although very rare, has been explained to me, particularly in patients with narrowing of the esophagus, and/or disturbance in swallowing. In such cases it may be necessary to make an operative repair. In much rarer cases this complication may lead to death.
In patients with unstable teeth or caries, injury to the teeth may occur.
I hereby give my consent to performance of the main examination.
My consent is also given hereby to the performance of local anesthesia using a spray, and of partial anesthesia with injection of sedative substances into a vein after it has been explained to me that sedative medications may cause breathing disturbances, especially in patients with severe lung disease. It has also been explained to me that in state of partial anesthesia aspiration of stomach contents into the lungs may occur, especially in patients who have not fasted.
I know and agree that the operation and the main examination 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's Signature License No.

* Cross out irrelevant option.

מחלקה קרדיולוגית

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