מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

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

טופס הסכמה: בדיקה אלקטרופיזיולוגית וצריבה באמצעות תדר רדיו
CONSENT FORM : ELECTROPHYSIOLOGICAL STUDY (EPS) AND RADIO FREQUENCY (RF) ABLATION

Electrophysiological study is intended for diagnosis of different rhythm disturbances, by insertion of a catheter through blood vessels into the heart cavity.
Ablation by means of radio frequency is intended for the treatment of the above rhythm disturbances.
The treatment is usually carried out under local anesthesia with or without giving a sedative.

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 the performance of an electrophysiological study and radio frequency ablation (hereafter " the primary treatment"). It has been explained to me that in most cases after RF ablation, rhythm disturbances will be avoided. I hereby declare and confirm that the side effects of the primary treatment have been explained to me, including: pain and discomfort in the region of insertion of the catheters.

I have also received an explanation regarding the possible risks and complications of the primary treatment including:

- damage to blood vessels in the region of the insertion of the catheters that is liable to lead to the need for an operation to repair them.
- damage to the pleura (covering of the lung) and/or puncture of the lung in cases in which the catheter is inserted through veins of the chest.
- perforation of the heart wall that is liable, rarely, to cause significant leakage of blood that will require drainage of the pericardial cavity by needle puncture and sometimes an urgent operation.
- damage to the conduction system of the heart that is liable to require implantation of a permanent pacemaker.
- migration of emboli from the heart to arteries of various organs with resulting damage that is liable to require immediate treatment including the possibility of an operation.

The frequency of each of the above complications is relatively low. In very rare cases these complications are liable to cause death.

I hereby give my consent to perform the primary treatment.
I also hereby declare and confirm that I received an explanation and understand the possibility that during the primary treatment 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 primary treatment.

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I also consent to carrying out local anesthesia and general sedation after I have received an explanation that sedative medications are liable to cause, rarely, disturbances of breathing and of heart function especially in

patients with respiratory or heart disease, and the possible risk of an allergic reaction of varying degrees to the local 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 primary treatment 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.