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

מדבקת פרטי מטופל

טופס הסכמה: ניתוח לשחרור אצבע הדק
CONSENT FORM: OPERATION FOR RELEASE OF TRIGGER FINGER

A "trigger finger" is the result of damage to the finger's flexor tendons, usually of an unknown cause. The operation is aimed at enabling normal finger motion by releasing the injured tendon. The incision is closed with sutures, which are removed after 10 days. Treatment of a "trigger finger" also includes post-operative physiotherapy.

The operation is performed under local and/or regional anesthesia, combined with a tourniquet positioned on the operated arm. The tourniquet may cause a sensation of pressure in the arm.

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 operation for repair of a "trigger finger" in the **right/left*** hand, in finger **1/2/3/4/5** (henceforth: "the primary operation").

I have been given an explanation concerning the expected results of the primary operation, which is meant to solve the problem in most cases.

I hereby declare and confirm that I have been given an explanation concerning possible side effects that may occur following the primary operation, including: pain, discomfort, and local hemorrhage that resolves spontaneously.

In addition, I have been given an explanation concerning the possible risks and complications, including: adhesions and limitation of motion that will require prolonged physiotherapy, infection in the surgical region, and neural damage, which is usually temporary. These complications may necessitate an additional operation to repair the damage.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that 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, 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 operation.

I hereby also give my consent for local and/or regional anesthesia, combined with a tourniquet, after being given an explanation concerning the risks and complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drugs, and the possibility of neural and/or vascular injury during the performance of regional anesthesia.

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

If the need to perform the primary operation under general anesthesia arises, I will be given an explanation about the anesthesia from an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated surgeon, 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.

______________	______________	______________
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.