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

טופס הסכמה : הכנסת צינור האכלה דרך דופן הבטן - גסטרוסטומיה בשיטה אנדוסקופית

CONSENT FORM: PERCUTANEOUS ENDOSCOPIC GASTROSTOMY – PEG

The introduction of a feeding tube into the stomach is performed when there is no possibility of eating or passage of food through the esophagus.

The procedure is carried out with the patient lying on his back. In the first stage an endoscope is inserted through the mouth into the stomach. An endoscope is a flexible instrument about 1.2 meters long and about 1 cm in diameter containing optic fibers, through which it is possible to see, and channels through which instruments can be passed.
Before the insertion of the endoscope the patient is given a sedative medication and/or a local anesthetic.
In order to perform the gastrostomy, a guide wire introduced through a small incision in the upper left wall of the abdomen, is grasped by the endoscope and brought out through the mouth. A feeding tube is introduced through the mouth and guided by the wire until it is brought out through the incision in the abdominal wall. At the end of the procedure, one end of the tube is in the stomach and the other outside the abdomen. Food is introduced through this opening.
In order to prevent infection as a result of introducing the gastrostomy tube through the abdominal wall, the patient is given antibiotic treatment at the time of the procedure.
The procedure takes about 30 minutes and is accompanied by discomfort and the feeling of a bloated abdomen.

Name of Patient: ________________ ________________ ________________ ________________
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have received a detailed verbal explanation from:
Dr. ________________ ________________
Last Name First Name
regarding the need for performing a gastrostomy by the endoscopic method for purposes of feeding ("the primary procedure").
I hereby declare and confirm that I received an explanation regarding the process of performing the gastrostomy and the side effects associated with carrying out the procedure including: pain, discomfort, and bloating of the abdomen.
I have also received an explanation regarding the possible complications including: infections of the skin and soft tissues and aspiration of saliva and secretions into the airways that will require treatment. In rare cases, bleeding or a tear of the digestive tract and leakage of stomach contents into the abdominal cavity in the region of the entry of the gastrostomy tube may occur. This will require surgical repair under general anesthesia.
I hereby give my consent to perform the primary procedure.
In addition, I hereby declare and confirm that I received explanation and understand the possibility that during the primary procedure or immediately thereafter the need to extend or modify its scope, or perform additional or different procedures, may arise, in order to save 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 or immediately thereafter.

מסי זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון: **מדבקת פרטי מטופל**

I hereby consent to receiving sedative medications and local anesthesia after it has been explained to me that the use of sedatives is liable in rare cases to cause disturbances of breathing and activity of the heart particularly in patients with respiratory or heart diseases, and also the possible risk of an allergic reaction of varying degree to the anesthetic medication.
I know, confirm and agree that the primary procedure 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.