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: ניתוח פילטרציה לחולי גלאוקומה

CONSENT FORM: TRABULECTOMY

The operation is performed to reduce increased pressure in the eye that causes damage to the optic nerve. Reduction of the pressure results from the creation of an alternative drainage system that bypasses the faulty drainage system of the eye. Sometimes antimetabolic substances are used during the operation to prevent closure of the opening to the drain. The operation is performed under local or general anesthesia.

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 operation for reduction of intraocular pressure in the left/right* eye (henceforth: "the primary operation").

I have received an explanation regarding the alternative methods of treatment under the circumstances of the case, the prospects, side effects and risks associated with every one of these procedures.
I hereby declare and confirm that I have received an explanation concerning the expected results, and the possibility of failure of the operation, that is, the intraocular pressure remaining high or even rising, and the side effects including pain and discomfort.
In addition the possible risks and complications during the course of the operation including bleeding into the eye and loss of the vitreous humor have been explained to me. The possibility of later complications including infection, cataract formation and drooping of the eyelid have been explained to me.
I hereby give my consent to perform the primary operation.
I also declare and confirm that I received an explanation and understand the possibility that during the process of the primary operation the need may arise to change it or to undertake other or additional measures including additional surgical procedures in order to save life or prevent bodily harm that cannot be fully or with certainty anticipated at the time, but whose significance has been explained to me. I therefore consent to such an extension, modification or performance of other or additional procedures or operations, which the institution's physicians deem essential during the primary operation.
I also give my consent for the performance of local anesthesia after the risks and complications of the local anesthesia have been explained to me including: bleeding, infection, harm to the eye and in rare cases loss of sight.
If it is decided that the primary operation will be performed under general anesthesia, I will receive an explanation from an anesthesiologist.

I know and agree that the primary operation 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)

יחידת עיניים

Medical Risk Management Co.

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

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.