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: טיפול בהמודיאליזה
CONSENT FORM: HEMODIALYSIS

Dialysis is substitution treatment for kidney function and is intended for persons suffering from advanced kidney failure. The treatment is essential for maintenance of life but does not result in restoration of health. The dialysis machine filters and rids the body of waste material, instead of the kidneys. In order to connect the patient to the dialysis machine, it is necessary to prepare a connection between an artery and a vein by operation (shunt) in one of the limbs. In certain cases, in the absence of such a shunt, a catheter is inserted temporarily to one of the body's veins. Insertion of a needle to the shunt or vein may cause pain and this may be carried out under local anesthetic.
In addition to the dialysis, it is necessary to adhere strictly to a special diet, take certain medications, and adopt a life style according to instructions from the treatment team.
The treatment is carried out a number of times a week, according to the state of the patient, in a dialysis unit in hospital or in the community. Every treatment takes a number of hours and after a short rest, the patient may generally return to usual activity.

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 treatment by hemodialysis. I received an explanation concerning the treatment process and the necessary life style.
Effects related to the treatment including weakness, discomfort and pain during insertion of the needle to the shunt or vein were explained to me.
Also possible complications of the treatment were explained to me: infection in the area of the shunt or general infection (septicemia), heart disturbances, a fall in blood pressure, bleeding because of medication to prevent clotting, anemia because of the necessity to take frequent blood samples and loss of blood during the treatment, disturbances of the digestive system, disturbances of the nervous system, bone diseases, acceleration of the atherosclerotic process (hardening of the arteries), air embolism that may cause paralysis and even death (rarely), and amyloid deposits in various organs.
I hereby declare that I also received an explanation concerning the possible alternative treatments to hemodialysis that are possible under the circumstances of the case including the risks and complications associated with every one of these treatments, and I hereby give my consent to carry out treatment by hemodialysis.
I also consent to the shunt operation under local anesthetic and if necessary general anesthetic. The possible complications of local anesthetic have been explained to me including an allergic reaction in different degrees to anesthetic materials, and nerve injury; and the possible complications in the case of the need for general anesthetic: including damage to teeth, injury to the vocal cords as a result of the intubation, and allergic reaction in different degrees to anesthetic materials that in very rare cases, may even end in death.
It has been explained to me that insertion of a temporary catheter, in the absence of a shunt, is associated with pain and may be complicated by infection, local or generalized, mild or severe. Bleeding as a result of injury to a large blood vessel may necessitate an operation to repair the injury. If the catheter is inserted to the subclavian vein, there is a risk of pneumothorax, which will necessitate the insertion of a drain into the chest.

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שם האב: תאריך לידה:
כתובת:
טלפון:

מדבקת פרטי מטופל

I know and agree that the operation and all the dialysis procedures will be carried out by whoever is designated to do so, according to the institutional procedures and directives of the hospital with the standard degree of responsibility and according to the law, and the physician responsible for insertion of the catheter will
be*:____

Name of physician

________________ ________________ ________________

Date Time Patient Signature

________________ ________________________________

Name of Guardian (Relationship) Guardian 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 Signature License No.

*Fill in the case of a private physician ** Cross out irrelevant option.