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 להקטנת שדיים
CONSENT FORM: BREAST REDUCTION

Breast reduction surgery is cosmetic surgery, and is at times performed for medical reasons.

The operation is performed under general anesthesia.

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 reduction of **both breasts / the right breast / the left breast** * (henceforth: "the primary operation").

I have been given an explanation concerning the alternative options in my circumstances, the advantages and disadvantages of each and their chances of success.

I have been given an explanation concerning the expected results of the primary operation and its limitations, including asymmetry of the breasts.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including pain and discomfort. In addition, I have been told that in some cases breast feeding is not possible following breast reduction surgery.

I have been told that in any case scars will remain on the breast and beneath it. I have been given an explanation that the form of scarring depends on my skin type and its healing qualities, and that in some cases, keloid scars may develop.

In addition, I have been given an explanation concerning the possible complications, including: hemorrhage, infection, gaping of the incision margins, impaired nipple sensation and the possibility of partial necrosis of the nipple and areola or part of the breast tissue which will infrequently require surgical intervention.

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, 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.

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I have been told that the operation is performed under general anesthesia and that I will be given an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the operation and any other procedure will be performed by any designated person, 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, and that the person in charge of the operation 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 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.
** Complete for private patients.