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: תיקון חסימה עורקית בגפיים התחתונות

CONSENT FORM: LOWER EXTREMITIES ENDARTERECTOMY/ ARTERIAL BYPASS

The purpose of the operation is renewal of the arterial blood supply to the limb because of narrowing or obstruction of the artery causing pain on walking, pain at rest and the appearance of ulcers to the extent of gangrene, features that may appear gradually or suddenly.

The repair can be carried out in two ways: (1) formation of a bypass of the obstructed and/or narrowed section by means of a venous or artificial transplant whose ends are connected to the artery above and below the obstructed section, (2) removal of the obstructing 'plug' and cleaning the narrowed section.

During the operation there may be a need for catheterization(s) of arteries with the use of contrast media. The use of the contrast media is liable to harm kidney function temporarily or permanently.
The operation is performed under general or regional anesthesia.

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

I hereby declare that I have received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the need for performing an operation _____
(indicate type of operation)
for correction of arterial obstruction of the lower extremities_____
(indicate site of obstruction)
_____ (hereafter: "the primary operation").

I have received an explanation concerning the side effects of the primary operation, including: pain and discomfort, and the possibility of the appearance of bleeding under the skin and swelling of the limb that may be extensive.

I have received an explanation concerning the possible complications and risks, including: bleeding, and/or infection that may require removal of the transplant. There is a possibility of formation of clots in the blood vessel that will require an additional operation for their removal. There is a possibility that the transplant, or the section that was cleaned will become blocked during the operation or immediately afterwards, and there will be need for a repeat operation to renew the circulation of blood. There may be damage to nerves of the limb expressing itself by decreased sensation and/or increased sensitivity and/or pain. Infrequently the damage may be permanent and require additional treatment. Bleeding, infection and obstruction of the transplant immediately after the operation are liable to lead to gangrene of the limb to the extent of requiring its amputation. The function of the transplant and its survival are associated with the type of transplant and the region of the body in which the bypass was performed and also the underlying disease that caused the obstruction/narrowing. A bypass of a synthetic implant carried out below the knee imposes a greater risk of limb amputation. The operation is liable to cause multiple system complications including also cardiac and respiratory complications that are liable to cause death.
I hereby give my consent to perform the primary operation.
In addition, I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need may arise to extend it, or to carry out other or additional procedures

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in order to save life or to avoid bodily 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 other or additional procedures including operations, which the institution's physicians deem essential or necessary during the primary operation.

I have been told that the primary operation is performed under general or regional anesthesia and that I will receive an explanation regarding the anesthesia 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, and that the physician responsible for the treatment will be_____.

Name of Physician

_____ _____ _____

Patient's Signature Time Date

_____ _____

Name of Guardian (Relationship) Guardian's Signature (for incompetent 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.

_____ _____ _____

License No. Physician's Signature Name of Physician

* Cross out irrelevant option.