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: היסטרוסקופיה

CONSENT FORM: HYSTEROSCOPY

Hysteroscopy is a procedure that enables direct observation of the cavity of the uterus for purposes of diagnosis or performing surgical procedures in the cavity. Diagnostic hysteroscopy may be performed without anesthesia, or with the aid of one of the local anesthesia techniques, including a possible combination of them. Operative hysteroscopy is carried out with regional or general anesthesia. In order to perform hysteroscopy it is necessary to dilate the cavity of the uterus with carbon dioxide gas or fluid. Following the procedure, rest for a number of hours in hospital is needed, and thereafter rest at home. Follow-up visits to the clinic are carried out according to the directions of the physician

Name of Woman: _____ _____ _____ _____
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 performing a **diagnostic/operative*** hysteroscopy (henceforth: "the primary procedure").

I declare and confirm that I have received an explanation regarding the possible side effects of the primary procedure including abdominal pain, pain in the diaphragm and shoulders, discomfort and mild bleeding that usually revert after a few days.
I have also received an explanation concerning the possible risks and complications including: infection, bleeding and/or perforation of the uterus that may require surgical repair. In rare cases infection or perforation of the uterus will necessitate excision of the uterus, and in very rare cases there may be damage to other internal organs, a complication that will necessitate surgical repair.
The possible complications of introduction of fluid into the uterine cavity have been explained to me including over-absorption of the fluid into the blood circulation and in rare cases pulmonary edema or "fluid poisoning".
The possible complications of gas into the uterine cavity have also been explained to me, including: air embolus in the lung, the heart or the brain and in very rare cases, death.
I hereby give my consent to perform the primary procedure.
I hereby declare and confirm that I received an explanation and understand the possibility that during the primary procedure the need to extend or modify it, or perform additional or different procedures, may arise, in order to save my 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.
I also give my consent to local anesthesia and to receiving sedatives after the possible complications of local anesthesia have been explained to me including allergic reactions of varying degree to the anesthetic substances and possible reactions to the sedatives that may, rarely, have side effects on the respiratory system and the heart mainly in patients suffering from heart or respiratory disease.
If it is decided to perform the procedure under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.

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טלפון:

מדבקת פרטי מטופל

I know, confirm and agree that the primary procedure or 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 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's Signature	License No.

* Cross out irrelevant option.