מס' זהות:
שם משפחה: שם פרטי:
שם האב: תאריך לידה:
כתובת:
טלפון: **מדבקת פרטי מטופל**

טופס הסכמה: כריתת האהוד הגבי העליון בתרוקוסקופיה בשל הזעת יתר בידיים

CONSENT FORM: THORACOSCOPIC UPPER DORSAL SYMATHECTOMY FOR PALMAR HYPERHYDROSIS

Palmar hyperhidrosis results from hyperactivity of part of the nervous system. Excessive perspiration can be reduced by cutting or excising the nerve responsible for the complaint. The operation is carried out by means of thoracoscopy. Thoracoscopy is a procedure performed by introducing instruments through small incisions on one or both sides of the chest.
The operation is carried out under 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 need for an operation for excision of the nerve responsible for palmar hyperhidrosis on the left/right/both* side(s) by means of thoracoscopy (henceforth: "the primary operation").
The possibility that the primary operation may not reduce perspiration significantly and/or that the perspiration may recur has been explained to me.
I declare and confirm that the possible side effects after the primary operation including: pain, discomfort, and excessive perspiration in other parts of the body have been explained to me.
The possible risks and complications have also been explained to me, including: bleeding that will rarely necessitate opening of the chest to stop the bleeding, drooping of an eyelid, and damage to organs in the chest. In the case of accumulation of air in the chest cavity, drainage by insertion of a tube into the chest will be required for a certain period.
The possibility of performing the operation by means of the "open method" has been explained to me.
After the operation by the "open method", its advantages and disadvantages have been explained to me, and I have considered both possibilities, I have elected and I hereby give my consent to perform the primary operation by thoracoscopy.
It has been explained to me that there is a possibility that during the operation it may become apparent that the nerve cannot be severed by means of thoracoscopy, and it will be necessary to change to the "open method".
I desire to continue/not to continue* with the operation according to the "open method", by means of an incision above the clavicle or in the armpit.

I hereby declare and confirm that I have received an explanation and understand the possibility that during the primary operation the need to extend or modify the operation, or perform additional or different procedures, may arise, in order to save 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 operation.
I have been told that the primary operation is performed under general anesthesia and that I will receive an explanation regarding the anesthesia from an anesthesiologist.

מסי זהות:
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כתובת:
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I know, confirm 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)

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.