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: לניתוח מיקרוגרפי בשיטת מוז
CONSENT FORM: MOHS MICROGRAPHIC SURGERY

Mohs micrographic surgery is a unique technique used to treat skin cancer. The operation is named after its inventor, Dr. Fredrick Mohs. The surgical technique is effective for most skin cancers, but is used primarily to treat basal cell carcinomas and squamous cell carcinomas. The Mohs surgery is conducted under local anesthesia, and, very infrequently, under general anesthesia. The operation involves resection of the affected tissue in thin layers throughout the perimeter and depth of the tissue. The resected tissue is mapped and processed in a laboratory adjacent to the operating room, using frozen sections, and examined under a microscope by the surgeon. Additional resections of any remnant cancer tissue are performed in the same manner, until healthy tissue is identified under microscopy. When the resection is complete, the damaged region is reconstructed. Reconstruction is performed by suturing the skin side to side, if possible, or by moving skin from an adjacent area (flap), or by implanting skin removed from a remote site. Recovery time following the operation until removal of the sutures is usually 7 to 14 days. A scar will remain at the surgical site. In many cases, it is delicate and nearly invisible, and in certain cases it is more apparent. The form of scarring is also dependant on each patient's skin structure and wound healing reaction.

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 Mohs micrographic surgery in the area of the _____
(henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation concerning the expected results, namely, that the Mohs micrographic surgical technique results in the highest healing rates and lowest recurrence rates for the tumor and enables maximal preservation of healthy tissue, thus reducing the potential for scarring or deformation.

It has been clarified that the extent of resection and absent tissue following the primary operation cannot be estimated prior to surgery; tissue loss is often much greater than the size of the tumor apparent to the eye before the primary operation.

I have been given an explanation concerning the alternative treatment options relevant to my circumstances, including: resection without microscopic control, freezing with fluid nitrogen, local radiation or destruction of the tumor by laser, including the benefits and risks of each of these treatments and the tests and procedures involved.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: redness, swelling, pain and discomfort.

יחידת כירורגיה פלסטית

Israel Medical Association
Israeli Association of Plastic Surgery
The Israeli Society of Dermatologic Surgery
The Israeli Association of Dermatology & Venereology

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In addition, I have been given an explanation concerning the possible complications during the primary operation and following it, including: local hemorrhage, local infection, opening of the sutures and non-

merging of the flap or graft as a result of the complications mentioned. These complications are not common. Additional complications dependant on operation:

_____

I hereby give my consent to perform the primary operation.

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

I hereby also give my consent to the administration of local anesthesia after having been given an explanation concerning the risks and complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug.

If the decision is made to perform the primary operation under general anesthesia, I will be given an explanation regarding the anesthesia by an anesthesiologist.

_____	_____	_____
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, and circle planned option.
** Complete for private patients.

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