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 אף

CONSENT FORM: RHINOPLASTY

The operation is conducted for cosmetic purposes and/or to improve passage of air.

The operation is performed following the administration of local anesthesia and sedatives, or 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 rhinoplasty operation for **cosmetic repair and/or to improve the passage of air.*** Following examination, it has been agreed to perform: **alignment of the septum / removal of the turbines / aesthetic repair *. Detail planned procedures:**
_____
(henceforth: "the primary operation").

I have been given an explanation concerning the expected results and the limitations of the ability to make modifications through surgery, dependant, amongst others, on the structure of my nose, the nature of the skin covering my nose and my age, and any unexpected findings which may be revealed during the primary operation.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: pain, discomfort, external and internal swelling that may even cause difficulty in breathing, and subcutaneous hemorrhages. I have been told that in any case of nostril surgery scars will remain at the base of the nostrils. I have been told 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, perforation of the nasal septum; disturbances in the sense of smell, stuffed nose and difficulty breathing for a prolonged period of time. In addition, there may be damage to deep tissues, such as muscles and the tear duct, and asymmetry of the nose.

I hereby give my consent to perform the primary operation.

In addition, 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, 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 surgical procedures, which the institution's physicians deem essential or necessary during the primary operation.

I hereby also give my consent to the administration of local anesthesia, with or without intravenous injection of sedatives, after having been given an explanation concerning the risks and complications of

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מדבקת פרטי מטופל

local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possible reactions to the sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with heart disease and respiratory disorders.

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.

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