



מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

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

טופס הסכמה : תיקון ניתוח במחלת פרטס CONSENT FORM: SURGICAL CORRECTION OF LEG-CALF-PERTHES

Surgery for correction of the Perthes disease is performed to reduce the damage and/or prevent additional damage caused by the disease to the hip joint. There are various surgical methods. The method will be selected according to medical considerations. In certain cases, more than one operation will be required to achieve the desired result.

The operation is performed 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 need for a _____ operation
in **the right leg / left leg / both legs*** (henceforth: "the primary operation").

I have been told that the desired outcome is not achieved in all cases and that additional treatments, including surgical intervention, may be necessary.

I hereby declare and confirm that I have been given an explanation concerning the alternative surgical options, and the advantages and disadvantages of each of these.

I have been given an explanation concerning the expected side effects following the primary operation, including: pain, discomfort and limitation of motion. In certain cases, there may be shortening of the bone and muscle weakness.

I hereby declare and confirm that I have been given an explanation concerning the possible risks and complications, including: infection that may require treatment and even surgery; impaired connection of the bone, which may require surgical intervention. In rare cases, during the operation, damage may be caused to blood vessels or nerves, leading to a functional disorder.

I hereby give my consent to perform the primary operation.

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 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 be given an explanation regarding the anesthesia by an anesthesiologist.

מחלקה אורתופדית



Israel Medical Association
Israeli Association of Orthopedic Surgery
Israeli Society of Pediatric Orthopedics



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I know and agree that the primary 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.

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.

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