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 לתיקון פזילה
CONSENT FORM: OPERATIONS ON EXTRAOCULAR MUSCLES

The operation is performed to improve the relative position of the eyes by shortening or lengthening the muscles outside the eye that are responsible for movements of the eyes. The operation does not alter visual acuity of each eye, but the appearance of the patient and sometimes the binocular function. The operation is a treatment option in a series of possible treatments that include: wearing glasses and/or covering one of the eyes as treatment for a lazy eye. Such treatments are carried out before and/or after the operation. At each operation one or two muscles in one or both eyes are operated on.

The operation is carried out under general or local 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 the correction of strabismus (squint) in the left/right/both* eyes, on one/two* muscles (henceforth: "the primary operation").

I hereby declare and confirm that I have received an explanation concerning the expected results of the operation that include changes in the angle of the squint including gradual additional improvement or worsening, that is, a return to the previous angle of squint or the appearance of another kind of squint. In these cases there is a possibility of another operation.
The possible side effects during the operation including bleeding, infection, and in very rare cases worsening of vision.
I hereby give my consent to perform the primary operation.
In addition, I hereby declare and confirm that I have received 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 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, or switching from a closed to an open approach. 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 also consent to the performance of local anesthesia after the risks and complications of local anesthesia have been explained to me, including: bleeding, infection, damage to the eye and in rare cases loss of vision.
If it is decided to perform the operation under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.
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.

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

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.

יחידת עיניים

Medical Risk Management Co.