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 לטיפול בהיפרדות רשתית
CONSENT FORM: REPAIR OF RETINAL DETACHMENT

An operation for treatment of retinal detachment is performed in order to fix the retina in place. The operation is performed using different methods that in most cases are combined with the injection of special material into the eye. Retinal detachment is a condition in which the retina is separated from its position and its ability to absorb visual stimuli is impaired. The main causes of retinal detachment are: injury, eye diseases (shortsightedness, retinal degeneration) or general illnesses such as diabetes. Treatment as early as possible is necessary to prevent irreversible damage.
The operation is carried out under local or 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 performing an operation for repair of a retinal detachment on the left/right* eye (henceforth: "the primary operation").
I declare and confirm that it was explained to me that there are no alternative options for the treatment of retinal detachment other than operation and/or injection of gas.
I hereby declare and confirm that I received an explanation concerning the expected results, and that in some cases it may be necessary to perform additional operation(s) in order to restore the retina to its place.
Side effects after the operation including pain, discomfort, redness and swelling, have been explained to me.
I have also received an explanation concerning the possible risks and complications including: hemorrhage and changes in refraction that will necessitate wearing glasses or change of previous glasses. Rarer complications include: drooping of the eyelid, double vision, increased intraocular pressure, infections and even complete loss of sight in the operated eye and shrinkage of the eyeball.
I hereby give my consent to perform the primary operation.

In addition, I hereby declare and confirm that I 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 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 hemorrhage, infection, damage to the eye and in rare cases loss of sight.
If general anesthesia is decided on, I will receive an explanation 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.

יחידת עיניים

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 above mentioned, 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.