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: לטיפול מטרש (סקלרותרפיה) בורידי הרגליים
CONSENT FORM: SCLEROTHERAPY

One of the methods of treatment for prominent varicose veins or venules ("capillaries") under the skin is injection of a sclerosing substance into the vein. There are a number of substances used for this purpose. The treatment, which is essentially cosmetic, includes a series of injections with the possibility afterwards of bandaging the leg at the discretion of the physician. The number of injections necessary depends on the distribution and quantity of varices and it is possible to repeat the procedure every two to three weeks. The process may continue for a number of months. The sclerosing substance is injected through a fine needle, and is accompanied by a mild pain with the puncture and a sensation of burning with the injection of the substance. Disappearance of the veins or venules is not absolute, and the injected area is liable to change color visibly many times.
The treatment does not avoid the appearance of new veins also in the area of injection.
The treatment is usually carried out without 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 treatment for the disappearance of veins by means of injection of the substance_____in the left/right* leg in the area(s)_____
(hereafter "the primary treatment).
I hereby declare and confirm that I have received an explanation regarding the possible alternative treatments in the circumstances of the case including an operation and laser treatment, the advantages and disadvantages of each of them, their chances of success and suitability to my condition. The expected results of the primary treatment have been explained to me, and also that there are cases in which the vein(s) react to the treatment partially or not at all. In these cases it is possible to repeat the treatment but
there is no guarantee of complete success of the treatment in all the veins in the leg.
I hereby declare and confirm that I have received an explanation of the side effects of the primary treatment including: pain, sensation of burning, discomfort, color change at the site of the injection and stripes in the course of the injected veins. In some of the cases an esthetic blemish may remain in the area(s) of injection.
I have also had the possible complications explained to me including: local infection, the formation of an ulcer or an area of necrosis at the site of injection that is liable to leave a scar at the end of the healing process. It has been explained to me that the type of scars that remain depend on the nature of my skin and its healing properties and that there are cases in which keloid scars may develop. In rare cases there will be a need for a repair operation in the area of necrosis of the skin.
It has been explained to me that in rare cases sensitivity of the body to the sclerosing substance injected into the vein may cause a local or general allergic reaction. In extreme cases that are very rare the allergic reaction may be severe.
I hereby give my consent to perform the primary treatment.
I know and agree that the primary treatment 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, and that the physician responsible for the primary treatment will be**_____
Name of Physician

מחלקה כירורגית

ההסתדרות הרפואית בישראל
האיגוד האורתופדי בישראל
החברה הישראלית לכירורגיה של הברך ולארתרוסקופיה

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

_____ _____ _____

Patient's Signature Time Date

_____ _____ _____

License No. Physician's Signature Name of Physician

* Cross out irrelevant option.
**In the case of a private patient