



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

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

טופס הסכמה:

ניתוח לכריתה שלמה / חלקית / אונתית של בלוטת התריס - בלוטת המגן

CONSENT FORM: THYROIDECTOMY (LOBECTOMY/PARTIAL/TOTAL)

An operation for excision of the thyroid gland is performed in cases of overactivity of the gland that does not react to conservative treatment, or because of a finding in the gland. The operation is performed under general anesthesia and during it, the finding, the gland or part of it is excised.

A drain is generally left in the region of the operation. When excision of one lobe of the gland is planned, there is a possibility that it may be necessary to excise the other lobe as a result of the histological finding at the time of the operation. As a result of the histological findings at a later date, an additional operation may become necessary.

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 total excision/partial excision/ excision of a finding* of the thyroid gland (hereafter: "the primary operation").

I hereby declare and confirm that I received an explanation concerning the expected results, and that the possibility that it may be necessary to take an iodine preparation after the operation to complete the treatment. It has also been explained to me that an operation scar will remain in front of the neck.

I declare and confirm that I have been given an explanation regarding the side effects of the operation, including pain and discomfort for a number of days. It may also be necessary to take substitute hormone preparations for the function of the gland immediately after the operation or at a later stage.

I have also had the risks and possible complications explained to me including: bleeding that sometimes necessitates repeat surgical intervention; infection in the region of the operation; hoarseness, transient or permanent as a result of damage to the recurrent nerve and rarely paralysis of the vocal cords; breathing disturbances that rarely necessitate tracheotomy (insertion of a tube through an incision into the windpipe); a decreased level of calcium in the blood due to damage to the parathyroid glands that may require prolonged or permanent medicinal treatment.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that I have received an explanation and understand the possibility that during the primary operation the need may arise to extend the operation, because of the histological report, or perform additional or different procedures, 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. 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 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



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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.

_____ 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.