



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: ניתוח וורידים דליתיים בגפיים תחתונות

CONSENT FORM: OPERATION FOR VARICOSE VEINS OF THE LEGS

Varicose veins of the legs are an expression of harm to the superficial venous system on a background of insufficiency of the venous valves and/or a defect of the walls of the veins.

Dilatation of the superficial venous system of the legs is liable to cause esthetic harm, a sensation of heaviness, swelling of the feet, inflammation of the veins, a change in the color of the skin of the feet and chronic ulcers.

During the operation the main vein of the superficial system in all its length and/or dilated sections of a vein in the length of the limb is/are excised, for the purpose of reducing the symptoms and signs resulting from dilatation of the venous system. There is a possibility that the excision will not include the main vein of the superficial system.

The operation is performed under general, regional or local anesthesia.

Name of Patient: _____
Last Name First Name Father's Name ID No.

I hereby declare that I have received a detailed verbal explanation from:

Dr. _____
Last Name First Name
regarding an operation for varicose veins _____
(indicate type of operation)

on the left/right/both * leg(s) (hereafter: "the primary operation").

It has been explained to me that it is not always possible to remove all the varices and not all the varicose veins will disappear as a result of the operation, and that there is a relatively high likelihood of the appearance of new and additional varices with the passage of time.

It has been explained to me that in any event scars will remain at the site of the incisions. The form and color of the scars depend on the properties of the skin and its healing ability; there are cases in which excessive scarring and/or keloid scars (protruding above the skin) will develop.

I declare and confirm that I have received an explanation concerning the side effects of the primary operation, including: pain, discomfort, and areas of bleeding under the skin that may be extensive. Sometimes a fine network of veins appears at the site of excision of the varices.

I have also received an explanation concerning the possible complications, including: infection and bleeding, nerve damage, expressing itself by decreased sensation and/or increased sensitivity and/or pain. The frequency of the sensation disturbance increases with the length of the section of the main vein that is excised. The nerve damage will be permanent and will require suitable treatment. There is also the possibility of the development of lymphatic edema (swelling) in the area of the ankle, which rarely is liable to remain permanently. In addition, there is a rare possibility of damage to large veins and/or arteries in the area of the upper thigh that will require immediate repair.



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

Rarely inflammation of the deep veins is liable to occur and will require suitable treatment.

I hereby give my consent to perform the primary operation.

In addition, I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need may arise to extend it, or to carry out other or additional procedures in order to save life or to avoid bodily 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 other or additional procedures including operations, which the institution's physicians deem essential or necessary during the primary operation.

I have been told that the primary operation is usually performed under general or regional anesthesia and that I will receive an explanation regarding the anesthesia from an anesthesiologist. I hereby consent also to the performance of local anesthesia after I have received an explanation regarding the risks and complications of local anesthesia including an allergic reaction of varying degrees to the anesthetic substances.

I know 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, and that the physician responsible for the treatment will be _____.

Name of Physician

Date Time Patient's Signature

Name of Guardian (Relationship) Guardian's Signature (for incompetent 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.