טופס הסכמה לניתוח אנדוסקופי של הסינוסים

CONSENT FORM: ENDOSCOPIC SINUS SURGERY

מדבקה גדולה

ESS / FUNCTIONAL ENDOSCOPIC SINUS SURGERY (FESS)

Endoscopic sinus surgery is mostly performed due to recurring sinusitis, chronic sinusitis non-responsive to medication treatment, polyps in the nose and sinuses, that do not regress with conservative treatment. Occasionally, the surgery is also performed due to tumors, cysts, foreign bodies, fungus. The purpose of the surgery is to remove the disease and improve the affected sinuses' drainage and ventilation. The scope of the surgery will be determined by clinical and radiological findings, during the surgery itself.

The surgery is performed through nasal approach without external incisions, with an endoscope, which is an optical device that allows the surgeon to see the surgery area up close and magnified. After the surgery, the surgeon may leave nasal tampons that cause discomfort.

In some instances, the need arises to combine the operation with surgery for correcting a nasal septum deviation and/or removing / reducing the conchae.

The operation is performed under general or local anesthesia.

Patient's Name (שם המטופל/ת): _____ _____ _____ _____
Last Name / שם משפחה First Name / שם פרטי Father's Name / שם האב ID No. / ת.ז.

I hereby declare and confirm that I have been given a detailed oral explanation by Dr. (ד"ר):

_____ _____
Last Name / שם משפחה First Name / שם פרטי

concerning the need to undergo sinus surgery with (עם) / without (בלי)* nasal septum surgery, with (עם) / without (בלי)* conchae surgery, on the (בצד) _____ side due to (בשל) _____ (henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation of the alternative modes of treatment that are possible in the circumstances of the case, as well as of the side effects, prospects and complications that these treatments involve.

It has been explained to me that there are cases in which re-operation is needed due to recurrence of the disease, chronic discharge or insufficient functional outcome. It is possible that more than one operation could be planned from the outset.

I hereby declare and confirm that I have been explained the side effects of the primary operation, including pain and discomfort.

In addition, I have been explained the possible risks and complications of the primary operation, including: bleeding; infection in the surgery area; scarring and adhesions between nasal mucosal tissue or the sinuses, even to the extent that re-operation is needed; impairment of the sense of smell; dryness in the nose; injury to the eye orbit - ranging from minor problems such as: minor bruising or eyelid puffiness, to, in rare instances, damage to the ocular muscles or vision acuity impairment to the extent of blindness; damage to tear ducts; damage to the meninges with leakage of cerebral fluids or meningitis; very rare cases of intracerebral impairment. Rarely, some of the complications could end in death.

I hereby give my consent to perform the primary operation.

מדבקה גדולה

I hereby declare and confirm that it has been explained to me and I have understood that there is a possibility that during the course of the primary operation, it will turn out that there is a need to be broaden its scope, alter it or to perform other or additional procedures for the purpose of saving life or preventing physical damage, including additional surgical procedures that cannot now be anticipated with certainty or completely, but their significance has been explained to me. I therefore consent also to such broadening, change or the carrying out of other or additional procedures, including surgical procedures that the institution's physicians will consider to be vital or needed during the course of the primary operation.

My consent is hereby given also for performing local anesthesia, with or without intravenous injection of sedatives, after having been explained the risks and complications of local anesthesia, including various levels of allergic reaction to anesthetics, and the possible complications of the use of sedatives, which rarely could cause disturbances to breathing and disturbances to heart function, mainly in people with heart disease and people with disorders of the respiratory system.

It has been explained to me that if the operation is performed under general anesthesia, an explanation of the anesthesia will be given to me by an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated physician, according to the institution's procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the standard degree of responsibility in the institution and in accordance with the law.

I, the undersigned, am aware that at the time of my discharge, the physician who operates on me might not be present in the hospital. In this case, I give my consent for any other physician to perform the discharge procedure on his behalf.

Date / תאריך	Time / שעה	Patient's Signature / חתימת המטופל/ת

Guardian's Name (Relationship) / שם האפוטרופוס (קרבה)	Guardian's Signature (for incompetent, minor or mentally ill patients) / חתימת האפוטרופוס (במקרה של פסול דין, קטין או חולה נפש)

I hereby confirm that I have given the patient (למטופל/ת) / the patient's guardian (לאפוטרופוס של המטופל/ת)* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

אני מאשר/ת כי הסברתי בעל פה למטופל/ת / לאפוטרופוס של המטופל/ת* את כל האמור לעיל בפירוט הדרוש וכי הוא/היא חתם/ה על הסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסברי במלואם.

Physician's Name / שם הרופא/ה	Signature / חתימה	License No. / מספר רישיון

* Cross out irrelevant option / מחק/י את המיותר