TLV MEDICAL
TLV מדיקל | הברזל 15 תל אביב
טל. 077-9807500 פקס. 03-5290231
www.tlvmedical.com

טופס הסכמה: ניתוח הרמת שדיים
CONSENT FORM: MASTOPEXY

This is cosmetic surgery. The operation can include the insertion of implants to enlarge the volume of the breasts. The operation is performed following the administration of local anesthesia and sedatives, or under general anesthesia.

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

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
regarding the **mastopexy** operation through an incision **below the breast / surrounding the areola / under the armpit * other _____, with / without * the insertion of** _____ **implant(s),** with a **volume** of
_____
(henceforth: "the primary operation").

I have been given an explanation concerning the expected results and the limitations of the ability to make modifications through surgery.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including pain and discomfort.

I have been told that in any case scars will remain in place of the incisions. The form of scarring depends on my skin type and its healing qualities, and in some cases, keloid scars may develop.

In addition, I have been given an explanation concerning the main risks and complications, including: hemorrhage, infection, temporary or permanent alterations in nipple and skin sensation, gaping of the incision margins, necrosis of the skin and/or areola and/or nipple and/or the deep tissues, and breast asymmetry. These complications may necessitate additional treatment and surgery.

I have been given an explanation concerning the possible risks and complications associated with the implant, including leakage or rupture of the implant shell, and expulsion or rejection of the implant which will necessitate its surgical removal; hardening and shrinkage of the implant capsule leading to discomfort and pain and/or deformity in the shape of the breast.

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It has been clarified that a relationship between implants and the development of cancerous diseases has not yet been unequivocally proven, nor has the association with certain rheumatic and neural phenomena that accompany diseases of the immune system (autoimmune diseases).

In addition, it has been clarified that the insertion of an implant may impair the ability to diagnose tumors by breast examination.

I have been told that if an implant is inserted, there will be a need for regular periodic follow-up, at least once a year.

I hereby give my consent to perform the primary operation.
I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures may arise, 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 hereby also give my consent to the administration of local anesthesia, with or without intravenous injection of sedatives, after having been given an explanation concerning the risks and complications of the local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possible complications of sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with heart disease and respiratory disorders. If the decision is made to perform the primary operation under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the operation and any other procedure will be performed by any designated person, according to the institutional 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 institution's standard degree of responsibility and in accordance with the law, and that the person in charge of the operation will be **

_____.
Name of Physician

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_____	_____	_____
Date	Time	Patient Signature

_____

Name of Guardian (Relationship) Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* 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.

_____	_____	_____
Name of Physician	Physician Signature	License No.

* Cross out irrelevant option, and circle planned option.

** Complete for private patients.