TLV MEDICAL

טופס הסכמה
לניתוח לשחרור "אצבע הדק"

CONSENT FORM:
RELEASE OF TRIGER FINGER

"Trigger finger" is the result of damage to the flexor tendons of the finger, the reason for which is usually unknown. The aim of the surgery is to enable normal movement of the finger/s, by releasing the affected tendon. The incision is closed with sutures, which will be removed after approximately 10 days. Treatment of "trigger finger" usually entalis physical surgery after the surgery.

The operation is performed under local and/or regional anesthesia combined with a tourniquet that is placed on the operated arm. The tourniquet could cause a sensation of pressure in the arm.

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. (מד"ר):

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

on the need for "trigger finger" repair surgery in the right (ימין) / left (שמאל)* hand, in digit (באצבע) 1 / 2 / 3 / 4/ 5* (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, including the prospects and risks involved in each of these procedures.

I have been explained the desired results of the primary operation that should resolve the problem in most cases.

I hereby declare and confirm that I have been given an explanation of the side effects that follow the primary operation, including: pain, discomfort and local hemorrhages that are spontaneously absorbed.

I have also been explained the possible risks and complications, incluing: adhesions and movement limitation that will necessitate prologed physical therapy, infection in the surgery area and nerve damage that is usually transient. These complications could necessitate repeated surgery to repair the damage.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that it has been explained to me and I understand that there is a possibility that during the course of the primary operation, it will turn out that there is a need to 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 made clear to me. I therefore consent 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.

רחוב הברזל 15 תל-אביב, טל: 077-9807500 פקס: 077-9807534

My consent is hereby given also for local and/or regional anesthesia in combination with a tourniquet, after having had the possible risks of local anesthesia explained to me, including various degrees of allergic reaction to anesthetics, and the possibility of neural and/or vascular damage from regional anesthesia.

If it is necessary to perform the primary operation 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 they are 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