



טופס הסכמה לניתוח כללי

**GENERAL CONSENT FORM  
FOR AN OPERATION**

(Intended for cases for which there is no specific form)

Patient's Name: (שם המטופל) \_\_\_\_\_

Father's Name / שם האב \_\_\_\_\_

First Name / שם פרטי \_\_\_\_\_

Last Name / שם משפחה \_\_\_\_\_

ID. No. / ת.ז. \_\_\_\_\_

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

First Name / שם פרטי \_\_\_\_\_

Last Name / שם המשפחה \_\_\_\_\_

concerning the need to perform the following operation: (על הצורך בביצוע ניתוח) \_\_\_\_\_

including the results that are hoped for, the reasonable risks and the alternative modes of treatment that are possible in the circumstances of the case, including the prospects and risks involved in each of these courses of action, the examinations and treatment involved in each of these courses of action, and the examinations and treatments involved.

I hereby give my consent to perform the above-mentioned operation in the hospital (henceforth: "the primary operation")

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, after it or to perform other or additional procedures, 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 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 operations that the hospital's physicians will consider to be vital or needed during the course of the primary operation.

I also give my consent for performing anesthesia, whether general or local, in the event that this is needed in the attending physicians' judgment, with the exception of ( \_\_\_\_\_ )

I know and agree that the 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.

Notes: (הערות: \_\_\_\_\_)

**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)/Guardian's Signature (for incompetent, minor or mentally ill patient's / קטין או חולה נפש / \_\_\_\_\_)

I hereby confirm that I have given the patient (למטופל/ת) / the patient's guardian (לאפוטרופוס של מטופל/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 / לאפוטרופוס של המטופל 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. / רישיון מספר \_\_\_\_\_