Herzliya Medical Center

טופס הסכמה: השתלת קוצב לב
CONSENT FORM: PACEMAKER IMPLANTATION

Pacemaker implantation is intended to protect the patient from a reduced heart rate that is liable to endanger him with fainting or even cardiac standstill. The implantation consists of the insertion of electrodes through veins into the heart, fixing them in the heart under x-ray screening, fitting the pacemaker and fixing it under the skin.
The treatment is usually carried out under local anesthesia with or without giving a sedative.

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

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the need to implant a pacemaker (henceforth: "the primary treatment").

It has been explained to me that in most cases after implantation of a pacemaker, the appearance of a reduced heart rate will be avoided.
I hereby declare and confirm that I have received an explanation regarding the side effects of the primary treatment, including: pain and discomfort in the region of the implantation of the pacemaker, which is liable to disturb movements of the hand on the side of the implantation.

I have also received an explanation regarding the possible risks and complications of the examination including:

- bleeding at the site of the implant that may sometimes require opening and drainage.
- damage to the pleura (covering of the lung) and the possibility of puncture of the lung by a needle, which sometimes requires insertion of a drain into the chest cavity
- perforation of the heart wall that is liable, rarely, to cause significant leakage of blood that will require drainage of the pericardial cavity by needle puncture and sometimes an urgent operation.
- displacement of one of the electrodes that will require a repeat procedure to replace it correctly.
- infection in the region of the procedure that is liable to warrant removal of the appliance and sometimes also prolonged antibiotic treatment.
- development of severe rhythm disturbances during the procedure that are liable to require administration of medicines or electric shock in order to stop them.

The frequency of each of the above complications is relatively low. In rare cases these complications are liable to cause death.

I hereby give my consent to perform the primary treatment.

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I also hereby declare and confirm that I received an explanation and understand the possibility that during the primary treatment the need to extend or modify it, or perform additional or different procedures, may arise, in order to save my life or prevent physical 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 different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary treatment.

I also consent to carrying out local anesthesia and general sedation after I have received an explanation that sedative medications are liable to cause, rarely, disturbances of breathing and of heart function especially in patients with respiratory or heart disease, and the possible risk of an allergic reaction of varying degrees to the local anesthetic substances.
If performance of the examination under general anesthesia is decided on, I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the primary treatment 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.

_____ _____ _____

Patient's Signature Time Date

_____ _____

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

_____ _____ _____

License No. Physician's Signature Name of Physician

* Cross out irrelevant option.