טופס הסכמה: כריתה לפרוסקופית של כיס מרה

CONSENT FORM: LAPAROSCOPIC CHOLECYSTECTOMY

Laparoscopic cholecystectomy is the standard procedure for treating gallbladder disease due to stones and/or inflammation. The procedure is also termed "closed method" and includes the introduction of instruments through small incisions in the abdominal wall.

The operation is performed under general anesthesia.

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 for a **laparoscopic cholecystectomy** (henceforth: "the primary operation").

I have been told that certain conditions require using the "open method" through an incision in the abdominal wall.

Even when the operation is performed laparoscopically, the need to switch to the "open method" may arise during the operation.

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

In addition, I have been given an explanation concerning the possible risks and complications, including: hemorrhage, infection, damage to the bile ducts which may lead to liver damage, and damage to other abdominal organs. In addition, there is a possibility that small stones will pass into the bile ducts during the primary operation, necessitating their removal at a later date. Some complications may require additional immediate or delayed surgery.

In addition, I have been told of the possibility that complications will not be diagnosed during the primary operation and a repair surgery will be required at a later date.

I hereby give my consent to perform the primary operation.

In addition, 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 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 hospital's physicians deem essential or necessary during the primary operation.

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It has been clarified that the primary operation is performed under general anesthesia, and in rare cases under regional anesthesia. I will be provided with an explanation concerning the anesthesia by an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by any designated surgeon, 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.

_____

Date Hour Patient's signature

_____ Guardian's name (relationship)

Guardian's signature (in case of incompetency, minor or mental patient)

I hereby confirm that I provided the patient/the patient's guardian* with an oral explanation of all of the above in required details and s/he signed the consent before me after I was convinced s/he fully comprehended my explanation.

_____

Physician's name Physician's signature License no.

* Strike out the irrelevant item