Space for Medical Institution Name and Logo

2000 יולי /VASUR/3842/3812/0049 ט

טופס הסכמה: ניתוח בעורק התרדמה

CONSENT FORM:

INTERNAL CAROTID ENDARTERECTOMY OR BYPASS

Narrowing (stenosis) of the carotid artery is a risk factor for the occurrence of strokes. The purpose of endarterectomies is to reduce the risk of a future stoke. The risk of a stroke is directly related to the degree of stenosis. When 70%, or more, of the artery is occluded, surgical treatment is more beneficial than continued conservative treatment in reducing the risk of strokes.

The surgical risk is also related to the degree of narrowing of the carotid artery on the opposite side, the extent of the disorder caused by the narrowing and additional concomitant diseases, especially cardiac disease. The operation is performed under general anesthesia or regional neural block.

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 need for an operation _____ (henceforth: "the primary operation").

I hereby declare and confirm that I have been given an explanation concerning the expected results and the possibility that in 10 - 15% of operations stenosis may recur months or years after the procedure. In some cases, an additional operation will be required.

I have been given an explanation concerning possible side effects that may occur following the primary operation, including: pain and discomfort.

In addition, I received an explanation concerning the possible complications, including: hemorrhage, infection and damage to the nerves of the tongue, the angle of the mouth and the vocal cords.

I was told that during or following the operation there is a risk of a stroke and/or heart attack that may cause various degrees of disability and even death. The overall rate of severe complications is up to 3 percent. The risk may be greater depending on the condition of the opposite carotid artery and the existence of additional concomitant diseases.

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 institution's physicians deem essential or necessary during the primary operation.

I was told that the primary operation is performed under general anesthesia or regional neural block and that I will be given an explanation regarding the anesthesia from an anesthesiologist.

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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	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.