

## Space for Medical Institution Name and Logo

2001 ינואר/OBGYN /LAP/5421/0054 ט

### טופס הסכמה : לפרוסקופיה גניקולוגית

## Consent Form: Laparoscopic Procedure in Gynecology

Laparoscopic gynecologic procedures enable visualization of the abdomen, for the diagnosis and/or treatment of intra-abdominal and intra-pelvic gynecological diseases and pathological conditions. Treatment options may include excision of organs, such as the ovary, the fallopian tube and the uterus.

Visualization of the abdomen is achieved by inserting an optic device near the navel and additional surgical instruments through small incisions in the abdominal wall. The procedure is performed with or without injection of CO<sub>2</sub> gas into the peritoneal cavity via a special needle. The recovery and convalescence following laparoscopic procedures is shorter than that of the traditional method of opening the abdomen – “the open method”, pain is usually milder and the scars are in most cases very small.

The procedure is usually performed under general anesthesia, but can also be performed under local anesthesia with the administration of sedatives.

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 a laparoscopic procedure for the purpose of \_\_\_\_\_ (henceforth: “the primary operation”).

I hereby declare and confirm that I have been given an explanation concerning the expected side effects, including: pain in the area of the incisions, shoulder pain caused by irritation of the diaphragm due to the insertion of air into the abdominal cavity, both of which usually subside within a few days.

In addition, I have been given an explanation concerning the possible complications, including: hemorrhage, damage to the abdominal organs or large blood vessels, or technical difficulty in performing the procedure which may require switching to the “open method”, that is, opening the abdomen to repair or complete the primary operation, and in very rare cases, death.

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

I have been given an explanation concerning the possibility of performing the procedure using the “open method”, including the side effects, risks and complications of this method and the duration of convalescence. After considering both options, I request and consent to perform the primary operation using the laparoscopic method.

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



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Name of Physician

Physician's Signature

License No.

\* Cross out irrelevant option.



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