Space for Medical Institution Name and Logo

/0012 ט' LDISC/ORT/NSR1997 /פברואר

טופס הסכמה: ניתוח כריתת דיסקה בעמוד שידרה מותני
CONSENT FORM: LUMBAR DISCECTOMY

The operation is performed to release the pressure from the nerve root or the dural sac by removal of the torn or degenerated cartilaginous disc that has burst from its position between the vertebrae causing pain and/or nerve impairment. The operation is carried out through an incision in the region of the lower back with separation of the tissues and displacement of the membrane covering the spinal cord. If necessary, the vertebral arch may be partially or totally removed (laminectomy).

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 performing an operation for excision of an intervertebral lumbar disc (henceforth: "the primary operation").

I hereby declare and confirm that I received an explanation concerning the expected results, and the side effects of the primary operation, including: pain and discomfort that will disappear gradually.
I received an explanation concerning the possible complications of the primary operation, including infection in the region of the operation, leakage of the spinal fluid that occurs rarely, and in the case of laminectomy, the possibility of instability of this section of the vertebral column. It has been explained to me that these complications may necessitate operations for their correction in the future. Rare complications including persistence of pain and signs of nervous impairment of different degrees up to complete paralysis of the lower limbs have been explained to me.
I hereby give my consent to perform the primary operation.

In addition, I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need may arise to extend it, and perform a laminectomy and/or an additional discectomy and/or fusion of vertebrae, and in the case of a repeat operation, also the removal of the previous operation scar, or to carry out other or additional interventions including additional surgical procedures and/or treatment of complications 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 other or additional procedures including operations that the institution's physicians deem essential or necessary during the primary operation or immediately thereafter.

I have been told that the primary operation is performed under general and/or regional anesthesia and that I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know, confirm 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 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.

Israeli Medical Association
Israel Orthopedic Association
Israel Neurosurgical Society

Medical Risk Management Co.

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Date	Time	Patient Signature

Name of Guardian (Relationship)	Guardian 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.

Name of Physician	Physician Signature	License No.

* Cross out irrelevant option.