Space for Medical Institution Name and Logo

ט 625/0052U/SURG/OUROL/ נובמבר 1997

טופס הסכמה: ניתוח להורדה וקיבוע של אשך טמיר
CONSENT FORM: ORCHIOPEXY (UNDESCENDED TESTIS)

Undescended testis is a congenital malformation in which the testis does not complete its descent into the scrotum.
The purpose of the operation is to lower the testis into the scrotum and to fix it there, in order to prevent problems in fertility and to facilitate early detection of other disease conditions. The operation is performed through an incision in the groin (inguinal region) and in the process the testis, the spermatic duct and blood vessels are freed from the sac of the testis and other adhesions in the region to enable the testis to be lowered into the scrotum.
In cases in which it becomes evident during the operation that the blood vessels of the testis are too short, the operation may be performed in two separate stages or it may be necessary to sever the testicular blood vessels from their site in the abdomen. This process is liable to result in atrophy of the testis.
If during the operation the undescended testis is found to be imperfect or undeveloped and cannot be lowered into the scrotum, it is recommended to excise it.
The operation is carried out 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 an operation for lowering the left/right* undescended testis (henceforth: "the primary operation").

I hereby declare and confirm that I received an explanation concerning the expected result that is giving the best prospect for the normal development of the testis. However it has been explained to me that a descended testis is liable to be imperfect from the beginning so that it may be necessary to excise it. Even if the testis is found to be normal there is no guarantee that the testis will develop normally after the operation and/or may not return to the region of the groin, thus necessitating an additional operation.
It has been explained to me that there is no alternative method of treatment for undescended testicle.
I declare and confirm that I have been given an explanation regarding the side effects of the primary operation, including: pain and discomfort.
I have also had explained to me the risks and complications including: infection, bleeding, damage to the spermatic cord and/or testicular blood vessels and/or the testis that may cause its atrophy.
I hereby give my consent to perform the primary operation.
I hereby declare and confirm that I have received an explanation and understand the possibility that during the primary operation the need to extend or modify the operation, or perform additional or different procedures, may arise, in order to save 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.

Israel Medical Association
Israel Pediatric Surgery Association
Israel Surgical Association

Medical Risk Management Co.

Space for Medical Institution Name and Logo

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 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.

Date	Time	Patient's Signature

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.

Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.