Space for Medical Institution Name and Logo

0053 ט/OUROL/SURG/A625/**1997 נובמבר /**

טופס הסכמה: ניתוח להורדה ולקיבוע של אשך תוך בטני
CONSENT FORM: ORCHIOPEXY (ABDOMINAL TESTIS)

Abdominal testis is a congenital malformation in which the testis remains in the abdominal cavity (the site of its formation in the fetal stage) and has not descended into the scrotum. This testis does not usual produce fertile sperm cells, and the frequency of the appearance of malignant tumors in it is high. For these reasons an operation is performed to lower the testis from the abdomen into the scrotum. The operation is performed through a small incision below the navel, through which a television camera is introduced to locate the testis. If the testis in the abdomen has atrophied (degenerated) or is found to have a deficient blood supply, it is excised (ORCHIECTOMY). In those cases in which the testis looks normal it is to be lowered into the scrotum. A testis in the abdomen usually has short blood vessels that do not permit its being lowered into the scrotum in one operation. In the first stage, after the testis has been identified in the abdomen, the blood vessels of the testis are tied in order to free it and lower it as far as possible. This procedure may cause the testis to atrophy. After a number of months, an attempt will be made to bring the testis into the scrotum.
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* intra-abdominal 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 appears 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 abdomen, thus necessitating an additional operation.
It has been explained to me that there is no alternative method of treatment for intra-abdominal 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 in the operation incision, bleeding, damage to the spermatic cord and/or testicular blood vessels and/or the testis that may cause its atrophy, damage to internal organs that will necessitate opening the abdomen in order to complete the primary operation and repair the damage.
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.

Israeli Medical Association
Israel Surgical Association
Israel Pediatric Surgery Association

Medical Risk Management Co.

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.