

Consent form

Total/Partial Laryngectomy

Laryngectomy is usually performed to remove a malignant tumor. In rare cases the indication may be due to a chronic disease, functional disorder or other condition. Sometimes, the procedure is accompanied by removal of lymph nodes in the throat and/or the thyroid. The decision regarding the extent of surgery and need for tracheostomy depends on the circumstances of the disease and the surgeon's discretion. Surgery is carried out under general anesthesia.

Patient's name: _____
Last name First name Father's name ID no.

I hereby declare and confirm having received a detailed oral explanation from Dr. _____
Last name First name

About the need for surgery due to _____

_____ (hereinafter: "the procedure")

I was informed the procedure involves disrupted speech or loss of voice, depending on the extent of surgery, and sometimes requires tracheostomy and temporary feeding by intubation, permanent tracheostomy, will change my lifestyle and requires dedicated training.

I hereby declare and confirm I received an explanation of the side effects of the procedure, including: aches and discomfort, decreased sensation (usually temporary) in the neck and facial skin.

Furthermore, I received an explanation of the possible risks and complications of the procedure, including: infection that may spread to other organs, bleeding that could be life threatening, perforation of the lung, perforation of the esophagus, fistula causing saliva or food leakage, lymphatic liquid leakage, difficulties swallowing, inhaling saliva or food into the lungs (in partial laryngectomy). Breathing difficulties, loss of sense of smell, disrupted brain function due to damage to the carotid artery, damage to the thyroid or parathyroid gland that could cause hormonal disruptions requiring permanent pharmaceutical treatment, disrupted tongue mobility, facial swelling, permanent decrease of neck skin sensation, neck skin necrosis and in rare cases death.

I hereby provide my consent to performance of the procedure.

I hereby declare and confirm that I have received an explanation and am aware of the possibility that in the course of the procedure the need may arise to extend its scope, modify it or use other or additional

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ההסתדרות הרפואית בישראל
איגוד רופאי אף-אוזן-גרון וכירורגיה של ראש צוואר



procedures to save life or prevent physical damage, including additional surgical procedures that cannot be foreseen certainly or fully at this stage, but their significance has been explained to me. I therefore also consent to said extension, modification or other or additional procedures, including surgical actions institution physicians believe to be vital or required during the course of the procedure.

I was informed that the procedure will be performed under general anesthesia, and the anesthetist will give me a relevant explanation about it.

I am aware of and consent to the procedure and all other procedures to be carried out by the person to whom it was allocated according to the institution's procedures and instructions, and I have not received any assurance that the procedure or a part thereof will be carried out by a particular person, provided it is carried out within the responsibility accepted by the institution and subject to the law.

Date	Hour	Patient's signature
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Guardian's name (relationship) Guardian's signature (in case of incompetency, minor or mental patient)

I hereby confirm that I provided the patient/the patient's guardian* with an oral explanation of all of the above in required details and s/he signed the consent before me after I was convinced s/he fully comprehended my explanation.

Physician's name	Physician's signature	License no.
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* Strike out the irrelevant item

Israeli Medical Association

Medical Risk Management Company Ltd.

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