

Consent form: procedure for examination of middle ear cavity and prosthetic hearing rehabilitation

The purpose of this procedure is to examine the cause of a conductive hearing impairment and reconstruct the hearing conduction mechanism. It is performed under general or local anesthetics with access through the ear or an incision behind the ear. Sometimes shaving the hair over and behind the ear may be necessary. The procedure is performed with a microscope and special instruments. Sometimes an additional incision in the temple, a vein in the hand or the auricle may be necessary in order to remove tissue for transplanting. In the event of stirrup fixation (otosclerosis), a special artificial prosthesis will be implanted (stapedectomy / stapedotomy). In cases of fixation or the detachment of other auditory ossicles, it will be released or hearing will be rehabilitated using a prosthesis, cartilage or the patient's auditory bone in a new location (ossiculoplasty).

The procedure is performed under general anesthetics (in children and adults) or local anesthetics (in some adults).

Patient's name: _____
Last name First name Father's name ID

I hereby declare and confirm I have been provided with a detailed oral explanation by Dr. _____ about the need to perform an ear exploration and/or stapedectomy and/or ossiculoplasty on the _____ side as a result of _____ (hereinafter "The Main Procedure").

It has been explained to me that in some cases a repeat procedure may be necessary in the event of failure to rehabilitate the patient's hearing. Months and even years after a successful hearing rehabilitation procedure, the prosthesis may dislocate or be expelled, and as a result the patient's hearing will deteriorate, requiring an additional procedure.

I hereby declare and confirm that the procedure's side effects have been explained to me, including bleeding, pain in the ear, numbness in the area of the procedure, pain in chewing, and possible alteration of the person's sense of taste.

Additionally, the Main Procedure's possible risks and complications have been explained to me, including: partial or complete hearing loss in the operated ear, temporary or prolonged impairment of the patient's balance (dizziness), a hole in the tympanic membrane requiring an additional procedure, tinnitus (noise in the ear) and paralysis of the facial nerve.

I hereby provide my consent to performance of the Main Procedure.

I hereby declare and confirm that I have been provided with an explanation and understand that it is possible to discover in the course of the Main Procedure that its scope must be extended or altered, or

החברה לניהול סיכונים ברפואה בע"מ



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



that other or additional procedures need to be performed in order to save the patient's life or prevent physical damage, including additional surgical procedures that cannot at this time be foreseen with any certainty or completeness but the significance of which has been explained to me. Therefore, I additionally agree to such alteration / extension of the procedure or to the administration of other or additional procedures, including surgical procedures that in the opinion of the institution's physicians will be essential or necessary in the course of the Main Procedure.

My consent is also hereby provided to the administration of local anesthetics with or without intravenous injection of sedatives, after having been provided with an explanation about the risks and complications of local anesthesia including varying degrees of allergic reactions to the anesthetics, and the possible complications of using sedatives that in rare cases may lead to respiratory impairments and cardiac function impairments, particularly in cardiacpatients and in patients with respiratory disorders.

It has been explained to me that if the procedure is performed under general anesthesia, an explanation about the anesthesia will be provided to me by the anesthetist.

I am aware and agree that the Main Procedure and any other main procedure will be performed by the person assigned to do so according to the institutions policies and instructions, and that there is no guarantee that all or any of the procedures will be performed by a particular person, so long as they are responsibly administered as is customary in 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 incompetent, minor or mental patient)

I confirm that I have explained to the patient / the patient's guardian* all of the above in appropriate detail and that he/she has signed this consent form before me after I have become satisfied that he/she fully understands my explanations.

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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