Space for Medical Institution Name and Logo

ט /ORTHO/HSRG/8221/0095 יולי 1998

טופס הסכמה: כריתת גנגליון
CONSENT FORM: EXCISION OF GANGLION

A ganglion is a cyst containing a viscous fluid, usually formed near a tendon or joint. In most cases its cause is unclear. An operation for the excision of a ganglion is performed in order to relieve the patient's pain or remove an unaesthetic mass.

The operation involves cutting an incision near the ganglion, releasing the tissues surrounding it, separating it from the joint of tendon sheath from which it emerges, and excising it.

If, during the operation, suspicion of a different type of tumor arises, the surgeon may decide to remove the entire tumor or take a biopsy for diagnosis purposes **as an initial stage.** The incision is closed with sutures that are removed after a few days.

The operation is performed under local and/or regional anesthesia, combined with a tourniquet installed on the operated arm, and at times, under general anesthesia. The tourniquet may cause a sensation of pressure on the arm.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
regarding the need to excise a ganglion from the **right / left *** arm, in the **wrist / hand *** area, on the **palmar / dorsal *** side, in finger **1 / 2 / 3 / 4 / 5 *** (henceforth: "the primary operation").

I have been given an explanation concerning the expected results of the primary operation and the high incidence of recurrence of the ganglion and the need for additional surgery to remove it.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: pain, discomfort, swelling and local hemorrhages that are spontaneously absorbed.

In addition, I have been given an explanation concerning the relatively rare risks and complications, including prolonged hemorrhage and infection that will require treatment. There is usually no need for physiotherapy following the operation.

I hereby give my consent to perform the primary operation.

I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures may arise in order to save my 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.

I hereby also give my consent to the administration of local and/or regional anesthesia combined with the use of a tourniquet, after having been given an explanation concerning the risks and complications of the local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possibility of neural and/or vascular damage with regional anesthesia.

If the decision is made to perform the primary operation under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the operation and any other procedure will be performed by any designated person, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

_____	_____	_____
Date	Time	Patient Signature

_____	_____
Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has 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.