Space for Medical Institution Name and Logo

ט /ORTHO/SHLDR/8182/0090 יוני 1999

טופס הסכמה: ניתוח לייצוב הכתף

CONSENT FORM: REPAIR OF RECURRENT DISLOCATION OF SHOULDER

Shoulder stabilization is performed in cases of recurrent dislocation or subluxation of the shoulder joint. The purpose of the operation is to achieve stability of the joint while aiming to maintain maximal range of motion. The operation can be conducted using the "open method" or the arthroscopic "closed method". The surgical method is selected at the surgeon's discretion.

The operation is performed under general anesthesia.

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 for an operation to repair a recurrent dislocation of the **right / left** * shoulder using the **closed / open** * method (henceforth: "the primary operation").

I have been told that the operated arm will be fixated for 3 to 8 weeks, based on the surgeon's decision and the surgical method, and that during this time I will not be able to use that arm. In addition, I am aware that following the operation I will require rehabilitative physiotherapy. I have been given an explanation that after surgery I will need to avoid sports activities for six months and any strenuous activity of the shoulder for one year.

I have been told that in any case a relative limitation of the shoulder's range of motion is expected after the operation.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including pain and discomfort.

I have been given an explanation concerning the possible risks and complications, including: infection that may sometimes necessitate additional surgery to treat the infection; neural damage that may impair the functioning of the shoulder and arm; recurrent dislocations of the operated joint. These complications are uncommon.

I hereby declare and confirm that I have been told of the possibility that during the primary operation it may be necessary to modify its course according to the intra-operative findings and/or switch from the "closed method" to the "open method".

I hereby give my consent to perform the primary operation.

In addition, 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 have been told that the primary operation is performed under general anesthesia and that 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 surgeon, 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.