Space for Medical Institution Name and Logo

1998 יולי/ORTHO/HSRG/8244/0096 ט

טופס הסכמה : ניתוח לתפירת גיד/ים ביד/ים
CONSENT FORM: REPAIR OF FLEXOR/EXTENSOR TENDONS

The purpose of the operation is to renew the ability to flex / extend the finger(s) damaged as a result of incision of the tendon(s).

The operation involves suturing the cut tendons end to end.

If, during the operation, it is discovered that the tendons cannot be sutured as mentioned, the surgeon will use, as far as possible, an alternative suturing technique so that the ability to move the finger(s) will be regained. When surgery is completed, the hand will be placed in a cast for 4 – 6 weeks. The surgical sutures will be removed after 10 days. During this period, and following it, a few months of physical therapy, physiotherapy and occupational therapy will be required.

The operation is performed under regional or general anesthesia, combined with a tourniquet installed on the operated arm. 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 suture the **flexor / extensor * tendon / tendons *,** of finger **1 / 2 / 3 / 4 / 5 *** of the **right / left** * hand (henceforth: "the primary operation").

I have been given an explanation concerning the expected results of the primary operation, including the possibility that it will be impossible to suture the tendons as planned and it will be necessary to select an alternative technique. In addition, I have been told that in many cases it is not possible to regain the full range of motion that existed before the injury.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: pain, discomfort and swelling of the hand which will require treatment. I have been given an explanation concerning the expected symptoms on removal of the cast, including stiffness of the operated hand and fingers, requiring physical therapy for a few months, and at times, repeat surgery to release adhesions.

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.

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

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.