יש למסור עותק למטופל

טופס הסכמה לניתוח חיתוך וניקוז של כלזיון

Consent form for an operation forsection and drainage of the Chalazion

מדבקה גדולה

Chalazion is a local inflammatory response that involves the sebaceous glands of the eyelid and occurs when the gland's drainage canal is blocked. Chalazion can go away by itself or by local massage and heating treatment and by maintaining the hygiene of the eyelids. When these methods do not cause improvement, the chalazion can be surgically cut and drained to drain the blocked gland and end the inflammatory process.

The surgery is performed by using a chalazion clamp around the visualization and performing a cut to the inner or outer surface of the eyelid. At this stage, careful drainage of the contents of the chalazion is performed, with or without excision of the blocked gland, and the use of gentle pressure or heat to control the bleeding. At the discretion of the surgeon, steroids can be injected into the chalazion bedding at the end of the surgery.

The form of anesthesia that accompanies this procedure: (circle the appropriate)

No Anesthesia (ללא הרדמה) / General (כללית) / Regional (אזורית) /Neural blockage (חסימהעצבית) / Local(מקומית)

I hereby declare and confirm that I have been given an explanation of possible alternative treatments for my condition, including:

1. Maintaining eyelid hygiene - including the use of warm eye patches, local massage and eyelid rim cleaning. This method may not improve inflammation if the chalazion is deep.
2. Local steroid injections - Steroids are anti-inflammatory agents. More than one injection may be needed. This treatment may cause eyelid de-pigmentation, accumulation of steroid residue at the injection site, or, in rare cases, rupture of retinal or choroid blood vessels with risk of visual loss.
3. Failure to provide treatment - I can choose not to receive treatment and stay with the chalazion.

It has been explained to me and I understand that there is a possibility that during the section and drainage of the chalazion it will become necessary to perform therapeutic procedures for the operation, such as the need for injecting an anti-inflammatory substance, making additional cuts to other foci, and using a hot needle to stop the bleeding.

In addition, the risks and possible complications have been explained to me, including:

1. Infection or significant bleeding.
2. Chronic pain and discomfort.
3. Change in skin tone due to surgery and / or injection of steroids.
4. Loss of eyelashes in the surgical area.
5. Notch formation in the rim of the eyelid in the inflammation area.
6. Mechanical stimulation of the surface of the eye and cornea by the surgical incision or surgical scar in the eyelid, which may cause damage to corneal abrasion cells, impairment of vision and foreign body sensation. This condition may require prolonged use of local preparations for lubrication, prevention of infections and, rarely, therapeutic contact lenses.

Patient's / Guardian's signature: _____
(**חתימת המטופל / אפוטרופוס**)

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7. Damage to the eyeball during surgery by surgical instruments such as the surgical knife, the needle used to inject the anesthetic or the steroid, or a utility used to burn the blood vessels.
8. Impaired vision and blindness.

I hereby declare and confirm that I have been informed and understand that there is a possibility that during the course of the primary operation / treatment it will become necessary to expand it, modify it or perform other or unforeseeable procedures to save lives or prevent bodily harm, including additional surgical procedures that cannot be fully or precisely predicted now. Therefore, I also agree to such expansion, modification, or performance of other or additional procedures, including actions that, in the opinion of the hospital physicians, will be vital or necessary during the primary surgery / treatment

It was explained to me that if the surgery is performed under **general / regional anesthesia / neural blockage**, the explanation regarding the anesthesia will be given to me by an anesthesiologist.

If performed under **local** anesthesia, my consent is also given for local anesthesia with or without intravenous injection of sedatives after I have been informed of the risks and complications of local anesthesia, including a varying degree of allergic reaction to the anesthetics and possible complications of sedatives that may rarely cause respiratory disorders and heart arrhythmias, especially in patients with heart disease and patients with respiratory disorders.

I know that in the event that the medical center has a university branch, students may take part in the evaluation and treatment under strictmonitoring and supervision.

I know and agree that the main surgery (except if a surgeon has been selected and coordinated in advance) and all other procedures will be carried out by the person designated for it, in accordance with the procedures and instructions of the Institution, and that I have not been promised that they will be done, all or in part, by a specific person, provided that they are performed under the accepted responsibility of the Institution, subject to the law.

I, the undersigned, am aware that it is possible that on the date of my discharge, the physician who will operate on me, will not be present at the hospital, in which case I agree that another physician will perform my discharge procedure.

I hereby give my consent to perform the main treatment.

Name of Patient (שם המטופל/ת): _____ _____ _____ _____

Last Name / שם משפחה First Name / שם פרטי Father's Name / שם האב ID No. / ת.ז.

I hereby declare and confirm that I have been given a detailed oral explanation by Dr. (מד"ר):

_____ _____

Last Name / שם משפחה First Name / שם פרטי

On the need to perform section and drainage of a chalazion (hereinafter: "the main surgery")

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The surgery will be performed in the: ☐ **Right Eye (עין ימין)**
☐ **Left Eye (עין שמאל);**
In the: ☐ **Top eyelid (עפעף ימין)**
☐ **Bottom eyelid (עפעף שמאל).**

Date / תאריך	Time / שעה	Patient Signature / חתימת המטופל/ת

Name of Guardian (Relationship) / שם האפוטרופוס (קרבה)	Guardian Signature (for incompetent, minor or mentally ill patients) / חתימת האפוטרופוס (במקרה של פסול דין, קטין או חולה נפש)

I confirm that I have explained orally to the patient / the patient's legal guardian / the patient's translator* all the information detailed above in the necessary details, and that the patient / legal guardian has signed the consent in my presence after I was satisfied that my explanations were understood in their entirety.

אני מאשר/ת כי הסברתי בעל פה למטופל/ת / לאפוטרופוס של המטופל/ת / למתרגם של המטופל* את כל האמור לעיל בפירוט הדרוש וכי המטופל / האפוטרופוס חתם/ה על הסכמה בפני לאחר ששוכנעתי כי הבין/ה את הסבריי במלואם.

Name of Physician / שם הרופא/ה	Signature / חתימה	License No. / מספר רישיון

Translator's name (שם המתרגם/ת)	Translator's relation to the patient (קשריו למטופל/ת)

* Cross out irrelevant option / מחק/י את המיותר