טופס הסכמה: ניתוח לתיקון של אי נקיטת שתן במאמץ
CONSENT FORM: STRESS INCONTINENCE

Stress incontinence (leakage of urine) is caused as a result of laxity of the support of the urinary bladder and the urethra that appears for different reasons and causes weakness of the sphincter mechanism and loss of control of passing urine.
The operation is done in cases in that stress incontinence results in severe hygienic and social problems and considerable interference with daily function.
There are a number of surgical approaches to the treatment of the problem. The type of chosen operation depends on the cause of the incontinence, the findings, the health state of the patient and the discretion of the surgeon.
The operation is carried out under regional or general anesthesia.

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

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the operation for correction of stress incontinence. **Detail the type/name of the operation and the surgical approach**_____

_____(henceforth: "the primary operation").

I have received an explanation regarding the possible alternative methods of treatment under the circumstances of the case, the chances of success and the risks in every one of these procedures. It has been made distinctly clear to me that complete success cannot be assured for the correction of stress incontinence by operation and in the long run its features are liable to recur.
I hereby declare and confirm that I have received an explanation regarding the side effects after the operation including pain, discomfort and difficulty in emptying the bladder. I have also received an explanation concerning the possible risks and complications during and immediately after the operation including: bleeding, infection of the urine and the operation incision; damage to the urinary bladder and vagina and in rare cases obstruction to the ureters. These complications are liable to require a change of operative approach, that is, moving from an abdominal approach to a vaginal approach or vice versa, or from a laparoscopic method to the "open method" and also treatments and/or operations in the future. I have also received an explanation regarding the possibility of late complications including: disturbances of urination of varying degree up to urinary retention for various and even lengthy periods; frequency and urgency of urination; prolapse of the uterus and walls of the vagina; chronic pelvic pain and pain on sexual intercourse.
I have also received an explanation regarding the possible additional complications relating to the surgical approaches as detailed: of the Marshall Marchetti Krantz operation – the possibility of chronic infection of the pubic bone; of laparoscopic operations – the possibility of damage to pelvic nerves; and of the Sling operation – the possibility of the formation of a fistula between the urethra or urinary bladder and the vagina. These complications are liable to need additional treatments/operations.
I hereby give my consent to perform the primary operation.

I hereby declare and confirm that I received an explanation and understand the possibility that during the primary operation the need to extend or modify the operation, or 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 primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

Date	Time	Woman's Signature

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

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.