טופס הסכמה: השראת לידה באמצעות פרוסטגלנדין E2
CONSENT FORM: INDUCTION OF LABOR BY PGE2/PGE1

Prostaglandin E2 is a medication given in the form of tablets, vaginal gel or solution for the purpose of causing labor contractions in cases in which the labor does not progress normally

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 induction of labor with prostaglandin E2 (hereafter: "the primary treatment"). I hereby declare and confirm that I received an explanation regarding possible alternative methods of treatment in the circumstances of the case, their side effects, prospects and complications of each one of these alternatives. It has been explained to me that the purpose of the primary treatment is softening the uterine cervix and initiation of labor contractions but there is also the possibility of failure of induction of labor.

I declare and confirm that I have been given an explanation regarding the side effects of the primary treatment including: nausea, vomiting, diarrhea, headache, fall in blood pressure, and spasm of the bronchi.

I have also had the risks and possible complications explained to me including: frequent and strong contractions of the uterus that will require medicinal treatment; changes in the pulse of the fetus; an allergic reaction to prostaglandin expressing itself by changes in blood pressure and depression of breathing. It has been explained to me that the rare possibility of a tear of the uterus will necessitate a cesarean section to deliver the fetus and repair of the tear and in rare cases even excision of the uterus. It has been explained to me that a tear of the uterus may cause the birth of an injured fetus or stillbirth.

I hereby give my consent to carry out the primary treatment.

I know, confirm and agree that the primary treatment 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 Patient'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.