Mayanei Hayeshua Medical Center | Department of Anesthesia

טופס הסכמה לביצוע חסם עצבי פריפרי

Consent Form for Peripheral Nerve Block

Label

If the operation is performed under anesthesia, an explanation will be given to me by an anesthesiologist and I will sign the designated, general, consent form for anesthesia.

The essence of the medical problem - pain.

The purpose of a peripheral nerve block is to reduce pain, whether as a single treatment or as an adjunct to medication. Peripheral nerve block, can also be given as a means of surgical anesthesia, separately, or as an adjunct to general anesthesia or sedation.

The nerve block is carried out by injecting preparations into or around nerves, which causes anesthesia of a certain area in the body. The effect of the nerve block usually terminates a few hours after the injection of the anesthetic has ceased.

It was explained to me that in most cases the injection should help relieve my pain, but this goal may not always be achieved.

Name of the nerve block planned for this operation (שם החסם העצבי המתוכנן לפעולה זו):

_____

Existing Alternate treatments for pain relief i.e. systemic pain relief medications were also presented to me.

It was explained to me and I understand the great importance of providing full information about my medical condition, all my illnesses, current medication therapy as well as known sensitivity to medications and / or anesthetics, reactions and complications following previous anesthesia of any kind, which occurred to me or to a member of my family.

I hereby declare and confirm that the possible side effects of this procedure including: pain and discomfort, pain and pressure when inserting the needle, temporary feeling of numbness and trembling at the beginning of the effect of the anesthetic; failure to relieve pain after surgery have been explained to me. It has also been explained to me that with the cessation of the anesthetic effect, it would be a while before sensation and movement in the anesthetized part of the body returns to normal and a recurrence of pain in increasing intensity may occur.

It was explained to me and I understand that there is a possibility that during the course of performing the peripheral nerve block it will become clear that it is necessary to perform local anesthesia, with or without intravenous injection of sedatives, by the physician performing the operation. My consent is hereby also given for performing this anesthesia, having been explained to me the risks and complications of local anesthesia including an allergic reaction to varying degrees to the anesthetics and possible complications of using sedatives that may rarely cause, respiratory and cardiac disorders, especially in patients with existing cardiac and/or respiratory disorders.

I was also explained the risks and possible complications, including: allergic reaction of varying degrees of severity, nerve damage and/or unintentional damage to the spinal cord, pneumothorax, short and transient epileptic seizure, infection in the injection site that may sometimes require surgical drainage and antibiotic treatment, hemorrhage in the injection area that might also require surgical drainage. Rarely, severe, and even irreversible neurological damage to nerve function may occur. The incidence of each of these complications is relatively low. In rare cases, these complications can be fatal.

Signature of patient / guardian: _____
(חתימת המטופל/ת/אפוטרופוס)

I hereby declare and confirm that it has been explained to me and I understand that there is a possibility that during the execution of a peripheral nerve block it may become clear that it is necessary to expand or change the scope, take additional actions and/or preform procedures that could not have been foreseen in advance in order to save lives or prevent bodily harm. Therefore, I declare that I agree to said expansion, change, performance of actions and/or additional or different procedures including operations that the Hospital physicians believe will be essential or necessary during or immediately after the main operation.

I know that since the Hospital is University affiliated and has recognized residency programs, residents and/or students may take part in my evaluation and treatment, under full staff supervision.

I agree that the treatments at the Hospital will be performed by any designated physician, according to the institution's 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 standard degree of responsibility in the institution and in accordance with the law.

I hereby give my consent to perform the main operation.

Patient's Name: _____ _____ _____ _____

(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 from the undersigned physician on all of the above, including the need to perform a peripheral nerve block (hereinafter the "main operation") as well as regarding the possible side effects and risks.

אני מצהיר/ה ומאשר/ת בזאת כי ניתן לי הסבר מפורט בעל פה מהרופא החתום מטה על כל האמור לעיל, ובכלל זה על הצורך בביצוע חסם עצבי פריפרי)להלן "הפעולה העיקרית"(וכן בדבר תופעות הלוואי והסיכונים האפשריים.

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

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

I declare that I have fully and completely translated for the patient the contents of this document and the physician's explanations into the _____ language / שפה.

אני מצהיר/ה כי תרגמתי למטופל באופן מלא ושלם את תוכן מסמך זה ואת הסברי הרופא לשפה

_____	_____	_____
Translator's name שם המרגם/ת	Relation to the patient קשריו למטופל/ת	Translator's signature חתימת המתרגם/ת

I hereby confirm that I have given the patient / the patient's guardian / the patient's interpreter* a detailed oral explanation of all the above-mentioned facts and considerations as required and that the patient / guardian has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

אני מאשר/ת כי הסברתי בעל פה למטופל/ת / לאפוטרופוס של המטופל/ת / למתרגם של המטופל/ת* את כל האמור לעיל בפירוט הדרוש וכי המטופל/ת / 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

* Cross out irrelevant option / מחק/י את המיותר