

**CONSENT FORM:
PTERYGIUM REMOVAL**

Pterygium is the growth of conjunctiva over the surface of the cornea, as compared to a normal eye where conjunctival tissue stops at the border between the sclera (white of the eye) and the cornea. During the pterygium removal operation, the pterygium tissue is removed from the surface of the cornea, and the place over the sclera from which the pterygium grew is treated by surgery and/or medications. In certain cases, in accordance with the physician's judgment, treatment with antimetabolite agent or local radiation is administered to prevent regrowth of the pterygium. More rarely, primarily after the recurrence of a pterygium that had been operated on in the past, conjunctival or corneal transplantation is performed.

The timing of the operation and the surgical method is decided upon taking into account the size of the pterygium, the patient's age, the condition of the conjunctiva and the position of the eyelid. Pterygium tends to recur, particularly at young ages, and the recurrence rate becomes smaller as age advances (a recurrence rate of 50% is reported in the literature). There is the possibility of not operating when the pterygium is not active, does not interfere with vision and does not disturb the patient esthetically.

The operation is performed under local anesthesia.

I declare and confirm that it has been explained to me that there are no alternatives to the surgical treatment of pterygium.

I hereby declare and confirm that I have been given an explanation of the results that are hoped for, including the possibility of recurrence of the pterygium. I have been explained the side effects, including pain, discomfort and local bleeding of the conjunctiva and eyelids, which usually resolve within a short time.

I have also been explained the possible risks and complications, including infection, refractive changes, double vision, the development of adhesions between the eyelid and eyeball (symblepharon), which could cause limitation of eye movements and double vision or traction of the eyelid and tearing.

I hereby give my consent to perform the primary operation.

I hereby also declare and confirm that I have been given an explanation and I have understood that there is a possibility that during the course of the primary operation, it will turn out that there is a need to broaden its scope, alter it or to perform other or additional procedures, including additional surgical procedures for the purpose of saving life or preventing physical damage, including surgical procedures that cannot now be anticipated with certainty or completely, but their significance has been made clear to me. I therefore consent to such broadening, change or the carrying out of other or additional procedures, including surgical procedures that the institution's physicians will consider to be vital during the course of the primary operation.

My consent is given also for performing local anesthesia, after having been explained the risks and complications of local anesthesia, including: bleeding, infection, damage to the eye, and in rare cases, loss of vision.

Patient's Signature / חתימת המטופל/ת: _____

I know and agree that the primary operation and any other procedure 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, the undersigned, am aware that at the time of my discharge, the physician who operates on me might not be present in the hospital. In this case, I give my consent for any other physician to perform the discharge procedure on his behalf.

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 by Dr. (מד"ר): _____
Last Name / שם משפחה First Name / שם פרטי

concerning the need to perform a pterygium removal in my right (ימין) / left (שמאל)* eye (henceforth: "the primary operation").

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

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

I hereby confirm that I have given the patient (למטופל/ת) / the patient's guardian (לאפוטרופוס של (המטופל/ת)* 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.

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

_____ _____ _____
Physician's Name / שם הרופא/ה Signature / חתימה License No. / מספר רישיון

* Cross out irrelevant option / מחקי את המיותר