



מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:	שם פרטי:
שם משפחה:	תאריך לידה:
שם האב:	כתובת:
טלפון:	מדבקת פרטי מטופל

טופס הסכמה : ניתוח לשאיבת שומן CONSENT FORM: LIPOSUCTION

Liposuction is a surgical technique used to remove excess fat concentrations from specific areas of the body. The operation is not a substitute for weight loss. As a result of liposuction, surgery to remove excess skin is sometimes required.

The operation is performed under general, regional or local anesthesia.

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

I hereby declare and confirm that I have been given a detailed oral explanation by:

Dr. _____
Last Name First Name
regarding liposuction surgery from the _____ area
(henceforth: "the primary operation").

I have been given an explanation concerning alternative treatments relevant to my circumstances, including: resection of excess skin and fat, and the risks and benefits of each of these procedures and the tests and treatments involved.

I have been given an explanation concerning the expected results and the limitations of the ability to make modifications through surgery, namely, that liposuction may at times not achieve the desired results and/or manifest in non-uniform contractions of the skin and the appearance of dimples or bulges on the surface. Bilateral liposuction may result in asymmetry.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including pain, discomfort and alterations, transient or permanent, in skin sensation.

I have been told that a scar will remain in those places where the liposuction device is inserted. The remaining scars depend on my skin type and its healing qualities, and in some cases, keloid scars may develop.

In addition, I have been given an explanation concerning the possible risks and complications, including: hemorrhage, infection and accumulation of fluids (serosa) in place of the suctioned fat. In addition, there is a possibility of damage to the skin, superficial and deep vein inflammation, and in very rare cases, pulmonary emboli.

I hereby give my consent to perform the primary operation.

I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures may arise, 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 surgical procedures, which the institution's physicians deem essential or necessary during the primary operation.



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I hereby also give my consent to the administration of local anesthesia, with or without intravenous injection of sedatives, after having been given an explanation concerning the risks and complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and the possible complications of sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with heart disease and respiratory disorders.

If the decision is made to perform the primary operation under general or regional anesthesia, I will be given an explanation regarding the anesthesia by an anesthesiologist.

I know and agree that the operation and any other procedure will be performed by any designated person, according to the institutional 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 institution's standard degree of responsibility and in accordance with the law, and that the person in charge of the operation will be ** _____.

Name of Physician

_____ Date _____ Time _____ Patient Signature

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

I hereby confirm that I have given the patient / the patient's guardian* 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.

_____ Name of Physician _____ Physician Signature _____ License No.

* Cross out irrelevant option, and circle planned option.

** Complete for private patients.

יחידת כירורגיה פלסטית



Israel Medical Association
Israeli Association of Plastic Surgery