Space for Medical Institution Name and Logo

2000 מרץ /OBGYN/6800/6829/0071 מרץ

טופס הסכמה: תסחוף (אמבוליזציה) של שרירני רחם (מיומות) CONSENT FORM: UTERINE FIBROID EMBOLIZATION

The purpose of the embolization of uterine fibroids is to reduce their size.

The procedure involves the introduction of a catheter(s) through a peripheral artery(ies) up to the area of the uterus, under x-ray guidance, and the injection of contrast medium (iodine) to visualize the blood vessels of the uterus and fibroid. The treatment is performed by injecting a sclerosing agent into the catheters located near the uterine fibroids, causing a reduction in their size.

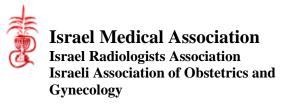
The procedure is	performed under l	ocal or regional ar	esthesia.	
Name of Patient:	Last Name	First Name	Father's Name	ID No.
DrLast Name	First Nan	me	detailed oral explanat by embolization (hence	·
•	g uterine fibroids,	_		ing alternative therapeutic ction of the fibroid and/or the

It has been clarified that the purpose of this therapeutic approach is, amongst others, to preserve the uterus, but there is a possibility of failure in which case an alternative treatment will have to be chosen. There is a possibility that after the introduction of the catheter it will not be possible to complete the procedure using this approach, and/or even if the procedure is completed, the desired result will not be achieved and a different therapeutic approach will be necessary. Approximately 15% of the procedures performed have been reported as unsatisfactory.

It has been clarified that this is an innovative treatment conducted successfully throughout the world for several years. However, like any new technique, its long term results can be evaluated only after several more years have passed.

I have been given an explanation concerning the side effects of the primary treatment, including: abdominal pain, and/or pain in other areas, fever, and at times even nausea and vomiting.

In addition, I have been given an explanation concerning the possible complications of the primary treatment, including: complications caused by the introduction of the catheter, allergic reaction to the injected agent, internal or external hemorrhage, formation of an emboli (blood clot), pelvic infection, perforation of the uterus and alterations in sexual function. Damage to the blood supply may cause alterations in the activity of the ovary(ies), in kidney function and in blood clotting. In addition, it has been clarified that the chances of conceiving in the future may be reduced, even though the uterus is preserved using this approach.



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It has been clarified that contrast medium containing iodine is used during the test and I hereby declare that I am not aware of any sensitivity to iodine or any other allergic reaction in the past.

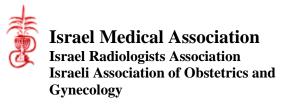
I hereby give my consent to perform the primary treatment.

In addition, I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary treatment the need to extend or modify the operation or to 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 and, therefore, I 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 treatment.

I hereby also give my consent to the administration of local anesthesia after having been given an explanation concerning the possible complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drug, and possible reactions to the sedatives, which may, in rare cases, cause respiratory disturbances and disturbances in the heart's activity, particularly in patients with respiratory or heart diseases.

If the decision is made to perform the operation under general or regional anesthesia, I will be given an explanation concerning the anesthesia by an anesthesiologist. I know and agree that the primary treatment and any other procedure will be performed by any designated physician, 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 procedure will be *

Date	Time	Patient Signature
hereby confirm that I have gi	ven the patient a detailed oral exp	lanation of all the above-mentione
•	, and that she has signed the conse	ent form in my presence after I was



^{*} Fill in case of private physician.