

**Clinics**

Haifa - Beit Harofim 4 Ben Gurion st.

Haifa 13 Sherit Hapleeta st.

Nahariya 21 Sokolov st.

**1800-331-441**

Tel. 972-4-8550930 טל.

Tel. 972-4-8550931 טל.

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[www.drgovrin.co.il](http://www.drgovrin.co.il)

**מרפאות**

חיפה - בית הרופאים, שד' בן גוריון 4

חיפה - רח' שארית הפליטה 13, דניה

נהריה - רח' סוקולוב 21

## Consent to nose surgery

The purpose of the operation is to correct the appearance of the nose and/or to improve the passage of air through the nose.

Name of the patient: \_\_\_\_\_ ID no.: \_\_\_\_\_

I hereby testify and confirm that I have received a comprehensive oral explanation by

Dr. \_\_\_\_\_ on: esthetic nose surgery / septum / removal of conchae/ esthetic repair\*.

Detail planned procedures.

I have received explanations on the anticipated outcome and the limited repair capability of the operation, related , among others, to the structure of the nose, the nature of the skin covering the nose and my age and unforeseen findings that may arise during the main operation. I am aware that it is not possible to evaluate the surgical outcome before a year from the treatment

I hereby testify and confirm that I have received explanations on the post-operative side- effects of the main operation including: pain, discomfort, nausea and vomiting of blood, external and internal swelling, up to breathing difficulties and subcutaneous bleeding.

I am aware that in any case of nostril surgery, scars will remain in the base of the nostrils. I received explanations that the shape of the scar depends on the type of my skin and its healing properties and there are infrequent cases where colloid scars develop.

Similarly, I have received explanations on the potential complications, including: bleeding, infection, perforation of the septum (in cases of septum repair); disturbances in the smell sensation, catarrh and breathing difficulties for a protracted period. Similarly damage to deep tissues is possible such as muscles and the tear duct, external damage to the skin of the nose and asymmetry of the structure of the nose as well as protrusion of the cartilages through the skin

I hereby give my consent to the performing of the main operation.

I have received explanations that the operation is performed under local anesthesia and deep sedation.

An explanation on general anesthesia, if necessary, shall be given by the anesthesiologist.

Similarly, I hereby testify and confirm that I have received explanations and I understand that there is a possibility in the course of the main operation that it will be necessary to extend its scope, to alter it or recur to other or additional procedures for the saving of life or prevention of bodily harm, including surgical procedures that cannot be foreseen now with certainty or in full; however, their significance was explained to me. Thus, I consent also to the aforesaid extension, alteration or performance of other or additional procedures, including surgical procedures that in the surgeon's opinion will be vital or necessary during the main operation.

I consent to the taking of pictures before and after the treatment for scientific, documentation and monitoring purposes.

I have received explanations that medicine and plastic surgery, in particular, are not an exact science, and that it is not possible to prevent complications and adverse outcomes entirely. The surgeon undertakes to treat assiduously any complication or adverse outcome. However, it was made clear to me that no pecuniary remuneration of any kind shall be awarded, for any post operative complication or adverse outcome. Similarly, there is no coverage for any financial or other damage incurred such as a loss of working days, purchasing of drugs, special trips, hospitalization, and/or any direct or indirect damage incurred in direct or indirect connection with the outcome of the treatment I am about to receive.

If after the recovery period of time, which is usually about a year, it is decided that a correction operation

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is indicated, it will be performed with the consent of both sides at the cost of usage of the operative room only.

I undertake to continue the periodic follow-up by the surgeon or the attending physician as they determine, and notify on time of any unforeseen change in the healing process.

I testify that I have had time to peruse it and receive another opinion of my choice.

Signature of the patient/guardian on the day of receipt of the form for the first time:

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of the patient/guardian for the second time: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

I testify that I explained to the patient/ guardian all the aforesaid in the necessary detail and that the signature was put after I was satisfied that my explanations were fully understood.

Stamp and signature of the physician: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_