J. GOVRIN M.D.
Plastic Surgeon - Specialist
O.J. Govrin Refua LTD

ד"ר ג'קי גוברין
מנתח פלסטי - מומחה
א.ג. גוברין רפואה בע"מ

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מרפאות
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נהריה - רח' סוקולוב 21

## Consent form: Eyelid surgery BLEPHORAPLASTY

The purpose of the operation is to remove surplus skin tissue and fat tissue from the eyelids. The operation does not eliminate wrinkles from the sides of the eyes. Sometimes it is also combined with a surgical repair of drooping of the eyelids (ptosis). This operation may be performed as part of face-lift surgery.
Usually this operation is performed under local anesthetic with the addition of sedative drugs.
First name: _____ Last name: _____ ID no.: _____
I hereby testify and confirm that I have received a detailed oral explanation by Dr._____ on upper/lower eyelid/both eyelids; on the right/left eye/ both eyes.
(hereinafter: "the main operation").
I have received an explanation that for me it is necessary/it is not necessary to stretch the eyelid sidewise, and/or upwards, with/without repair of the ptosis.
I hereby testify and confirm that I have received an explanation on the post-operative side-effects following the main operation including: pain, discomfort, swelling of the eyelids, nausea and vomiting, dryness of the conjunctiva or tears, subcutaneous bleeding around the eyes, redness of the eyes, and itching. The scars will be clearly visible for several weeks and subsequently, will be blurred to a great extent; however, they will be always visible from a short distance.
Similarly, I have received explanations on the potential complications including: infection, development of cysts at the suture site, prominent scars, alteration of the shape of the aperture of the eye, pulling of the eyelid, harm to the tear glands that will cause dryness of the conjunctiva or tears, itching of the cornea, chronic pain at the operation site, transient or permanent shading of eyelashes (on the lower eyelids), asymmetry of the two sides of the eye, and in rare cases, bleeding that necessitates an emergency operation. In cases of ptosis repair, it is sometimes necessary to treat both eyes.
There may be asymmetry between the eyelids, and similarly, an early or late injury to the cornea due to the internal sutures.
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. I will receive explanations on general anesthesia by the anesthesiologist.
Similarly, I hereby testify and confirm that I have received explanations and I understand that there is the possibility that during the main operation, it will be necessary to extend its scope, to alter it or conduct other or additional procedures for saving life or preventing bodily damage, including surgical procedures that are not certain or fully foreseeable now, but their significance was made clear to me. Thus, I also consent to that extension, alteration or performance of other or additional procedures that in the surgeon's opinion, are vital or necessary during the main operation.
I consent to the taking of pictures before and after treatment for purposes of science, recording, and monitoring.
I have received explanations that medicine and plastic surgery, in particular, are not an exact science, and that it is not possible to prevent entirely complications and adverse outcomes. The surgeon undertakes to treat assiduously any complication or adverse outcome; however, it was made clear to me that no pecuniary indemnification of any kind will be awarded, for a post-operative complication or adverse outcome. Similarly no coverage will be awarded for any pecuniary or other damage incurred in connection with the treatment such as a loss of working days, purchasing of

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drugs, special trips, hospitalization, and/or any direct or indirect damage incurred in direct or indirect connection with the outcome of the treatment that I will receive.
If a decision is taken after the recovery period, that usually takes a year, that corrective surgery is necessary, it will be performed with the consent of the 2 parties and at cost price.
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 to receive another opinion of my choice.
Signature of the patient/guardian on the day of receipt of the form for the first time: _____
Time: _____ Date: _____
Signature of the patient/guardian for the second time:_____
Date: _____Time:_____
I testify that I have 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: _____