אנגלית

STATE OF ISRAEL
Ministry of Health

Form 5 (Regulation 12 (5))

טופס זכויות וחובות למתאשפז ביחידה פסיכיאטרית

RIGHTS AND OBLIGATIONS OF AN INPATIENT IN A PSYCHIATRIC UNIT FORM

In pursuance of Section 35 (6) of the Treatment of Mental Patients Law, 5751 – 1991

1. In order to be hospitalized, check the mental and physical medical examinations.

2. When you are admitted to the hospital, you will be given a general description of the hospital, your condition and the need for hospitalization; you will also be given information and an explanation of your rights and obligations.

3. Your hospitalization is contingent on your consent unless you have been hospitalized –
   (1) By virtue of a Court Order;
   (2) By virtue of an instruction for hospitalization of the district psychiatrist;
   (3) In accordance with the determination of the hospital director as to the urgent need for you to be hospitalized.

4. On your admittance to the hospital, you will be asked to sign a form of consent for the receipt of treatment; if you were hospitalized voluntarily, you will be given medical treatment, other than emergency treatment, only with your consent; this consent does not cover special treatments to which you will be asked to consent separately. If you refuse medical treatment, the director of the hospital may discharge you from the hospital.

5. Your hospitalization will be extended until your medical condition makes your release possible. If you were hospitalized voluntarily, it is your right to request, in writing, that the director of the hospital discharge you from the hospital; the director of the hospital is bound to discharge you within 48 hours of the date of submission of your request unless within the said period of time, an instruction for hospitalization is issued against you as a result of your medical condition.

6. If you were hospitalized by virtue of an instruction for hospitalization of the district psychiatrist, it is your right to appeal this before the district psychiatric board. You may submit your application to appeal your hospitalization through the hospital director, the district psychiatrist or the head of the mental health services in the Ministry of Health.

7. If you were hospitalized by virtue of a Court Order for Hospitalization or an instruction of the district psychiatrist – you will be given treatment, including special treatment, even without your consent.

8. You will not be transferred from the institution in which you are hospitalized to another psychiatric institution without your consent, if you object to the transfer - you will not be transferred other than with the consent of the district psychiatrist and in special cases – the instruction of the head of the mental health services in the Ministry of Health.

9. The principal aim of your hospitalization is the receipt of medical treatment, it is your right to receive medical and nursing care, food and medications in accordance with your medical condition, both physical and mental, on the terms and arrangements that are customary in the Israeli health system. If you do not have any economic resources at your disposal, the hospital will provide you with pocket money as is the accepted practice.
10. It is your right to keep personal possessions to a reasonable extent, to wear your personal apparel, all in accordance with your condition and the customary practice at the hospital.

11. It is your right to maintain contact with the members of your family and your friends, by telephone, by sending and receiving closed letters and receiving guests during visiting hours. Postal and telephone fees will be at your expense; even if your medical condition does not permit maintaining all the aforesaid contacts, your right is reserved to send closed letters to your lawyer, your guardian, the district psychiatrist and the Attorney General.

12. You are entitled to move freely in the hospital. If your medical condition does not permit this, your physician may decide on restriction of movement until your condition improves; vacations outside the hospital are part of the treatment program and will be given to you at the discretion of the staff that are treating you.

13. Any information that you communicate or that is communicated in connection with you is confidential; the staff treating you will forward information concerning you only to the competent medical bodies, or according to law. Information will be communicated to any other body such as: members of your family, your friends, various institutions with your consent, or in taking your medical condition into account, at the discretion of the staff treating you.

14. You are entitled to receive information on your condition; this information will be communicated to you at the discretion of the physician.

15. The Ministry of Health has the right to determine the extent of your contribution to the hospital fees in accordance with the regulations on this matter.

16. It is your right to keep and manage your property while you are hospitalized unless the director determines, in writing, that you are incapable of seeing to your affairs. You may appeal any such determination before the psychiatric boards.

17. The hospital will permit you to keep your faith, your culture and your customs.

18. You are obligated to consider others, to respect the staff and all persons who are to be found in the hospital. You must maintain the cleanliness, the quiet and the privacy of other patients and not to injure their person or their property.

19. The staff regards you as an active partner in the program for your treatment and changes therein; the furtherance of your treatment depends to a great extent on your cooperation. The staff expects you to take an active part in activities, treatment and the various programs that are intended for you.

I hereby confirm that the written contents were explained to me:

_________________________ _________________ ________________

Name of the Patient | Identity Number | Patient's Signature

____

Name of staff member who explained the contents of the form to the patient

_____________ ______________________ _______________

Position | Staff Member's Signature | Date

Copies: A family member
The patient's file

154 b from the new version August 1992

אני מאשר כי הטופס נחתם בפני

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שם | תפקיד בבית חולים | חתימה | תאריך

STATE OF ISRAEL
Ministry of Health
Form 6 (Reg. 13(a))

הסכמה לאשפוז מרצון ולקבלת טיפול

Consent to Voluntarily Admission and Treatment
Under Clause 4(a). Mental Patients Treatment Act. 1991

1) I, ________________________________ | | | | | | | | | |
Last Name First Name Father's Name ID No.

about to be admitted to*/ a patient in* ________________ psychiatric hospital, hereby declare, and affirm by my signature to this document, that I consent to be an inpatient in a psychiatric hospital and that the medical reasons for my admission, the terms under which I am admitted, and the treatment options have been explained to me and I have understood them.

I give my consent to the physicians, the nursing staff, and all other workers, both those employed by the hospital and those brought in by it, choosing and carrying out the tests and treatment I require in accordance with their professional judgment and circumstances.

I affirm that I have received no promise as to the outcome of the medical treatments, tests, and procedures which I shall undergo in the hospital, and that I know that my treatment in the hospital will performed by the person or persons required to do so by hospital instructions and procedures and that consent to this. I hereby declare that I have received no promise that all or part of my treatment will be carried out by a certain person.

Name and Signature of Patient* / Guardian*

____
Last Name First Name Signature Date

____
Address

2)**Name and Signature of person bringing the patient to hospital for admission:**

I hereby confirm that the patient signed the form of consent to admission and treatment in my present:

____
Last name First Name Signature Date

____
Relationship to Patient

____
Address

3)I hereby confirm that this form was signed in my presence:

____
Last Name Function Signature Date

* Delete whichever does not apply

אני מאשר כי הטופס נחתם בפני

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שם תפקיד בבית חולים חתימה תאריך

STATE OF ISRAEL

Ministry of Health

הסכמה של מאושפז מרצון לקבלת טיפול מיוחד

Consent of Voluntarily Admitted Patient to Special Treatment

Under Clause 4(a). Mental Patients Treatment Act. 1991

1) I, ______________________________ | | | | | | | | | |

Last name First Name Father's Name ID No.

a patient in ________________________________ Department,

hereby declare, and affirm by my signature to this document, that my medical state and the special treatment I require have been explained to me, including the need for an anesthetic and the outcomes likely to result from the treatment, and I have understood them.

Treatment: ____

I have received the explanation from: ______________________

Name

Function

I give my consent to the physicians, the nursing staff, and all other workers carrying out the treatment I require in accordance with their professional judgment and circumstances.

I affirm that I have received no promise as to the outcome of the medical treatments, tests, and procedures which I shall undergo in the hospital and that I know my treatment in the hospital will be performed by the person or persons required to do so by hospital instructions and procedures and that I consent to this. I hereby declare that I have received no promise that all or part of my treatment will be carried out by a certain person.

Name and Signature of Patient* / Guardian*

____

Last Name First Name Signature Date

____

Address

2)I hereby confirm that this form was signed in my presence:

____

Last Name Function Signature Date

* Delete whichever does not apply

אני מאשר כי הטופס נחתם בפני

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שם תפקיד בבית חולים חתימה תאריך

STATE OF ISRAEL
Ministry of Health

Authorizations for Administering Electro- convulsive Therapy
הסכמה לקבלת טיפול בנזעי חשמל

1) The consent of the patient / family / guardian to electro-convulsive therapy.

A. (The patient), I, the undersigned ______________________|_|_|_|_|_|_|_|_|_|
Surname Forename Identity number
Address:____

B. (Relative or guardian) ______________________|_|_|_|_|_|_|_|_|_|
Surname Forename Identity number
relation: _____________ address: _____________________ tel: _____________

hereby declare that after I/we have been explained in comprehensible language about the medical condition of the patient and the need for special electro-convulsive therapy, including anesthesia, and the consequences that may result from the aforesaid special medical treatment,
I/we hereby give my/our consent to the special medical treatment/s as stated above.

____________________ _________________________ ________________________
Signature of the patient Name and signature of relative Name of witnessing physician

___________ ____________ ___________________________ __________
Date Date Department Date

2) Confirmation of the patient's physical fitness to receive electro-convulsive therapy.

I, the undersigned, confirm and attest to having examined the patient and examined his medical record, and after examining the results of laboratory tests and accessory tests, I have reached the conclusion that there is no medical contraindication to electro-convulsive therapy.

__________________ _____________________________________ _______________
Date Signature of internist physician Stamp

3) Confirmation of the patient's neurological fitness to receive electro-convulsive therapy.

__________________ ____ ______________
Date Signature of neurologist Stamp

4) Psychiatric medical confirmations.

We, the undersigned, confirm and attest that we have examined the patient and/or examined his medical record and have reached the conclusion that the aforementioned needs electro-convulsive therapy.

______________________ _______________________________ ___________________
Department manager Manager of ECT unit Director of hospital

______________________ ____
Date Date Date

אני מאשר כי הטופס נחתם בפני

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שם תפקיד בבית חולים חתימה תאריך