ENDOSCOPIC PROCEDURE CONSENT FORM

PATIENT NAME: ____ **DOB:** _______________

1. I hereby authorize Dr. Chris Demetriou, Dr. Sridevi Bhumi, Dr. Steven Rubin, Dr. Haseeb Ahmed, Dr. Amy Tan and assistants including the anesthesiologist Dr. Parvis Soomekh, Dr. Andrew Davy, Dr. Stacy Serebnitsky, Dr. Steve Shay as may be designated by him to evaluate and/or treat the condition and/or conditions that appear indicated. ____

2. I am giving my consent for:

- ○ **Upper endoscopy** with possible biopsy, brushing, submucosal injection, cauterization, polypectomy, dilation, hemostasis, foreign body removal, extension to an Enteroscopy, photography for medical documentation and other.
- ○ **Colonoscopy** with possible biopsy, brushing, submucosal injection, cauterization, polypectomy, dilation, hemostasis, foreign body removal, hemorrhoid treatment, extension to an Endoscopy or Enteroscopy, photography for medical documentation and other.
- ○ **Flexible Sigmoidoscopy** with possible biopsy, brushing, submucosal injection, cauterization, polypectomy, dilation, hemostasis, foreign body removal, hemorrhoid treatment, extension to a Colonoscopy, Endoscopy or Enteroscopy, photography for medical documentation and other.
- ○ Other: ____

3. I am giving my consent for Anesthesia, Sedatives, Analgesic agents as may be considered necessary or advisable by the physician responsible for this service. The physician providing this service has explained to me the nature and purpose of the anesthesia; risks, benefits, clinical outcome if I elect not to have anesthesia and alternative to various types of anesthetics, sedatives, or analgesic agents.

4. I am giving my consent to treat all my conditions that require evaluation or treatment, including those not known to the Physician(s) at the time the procedure commenced. I have been made aware about my medical condition(s) and reasonable diagnostic and treatment alternatives to help with my medical condition. I have also been made aware of the possible results of not undergoing evaluation and/or treatment for my above condition.

5. I have been made aware of the potential benefits, certain risks, side effects, hazards, complications and consequences that are associated with the Endoscopic procedures, Infrared coagulation, and Anesthesia. **Risks include but are not limited to:** Perforation possibly requiring emergent surgical intervention, bleeding possibly requiring a blood transfusion, infection, missed lesions, sore throat, hoarseness, corneal abrasions and damage to teeth, I.V. problems, allergic reactions, awareness under anesthesia, pneumonia, stroke, seizure, cardiopulmonary distress including cardiopulmonary arrest, and death. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurances have been made to me concerning the results or outcome of the above procedure including interventions associated with that procedure.

6. I consent to disposal by the endoscopic facility, in accordance with its accustomed practice, of any tissue or blood samples that may be removed and sent to the laboratory for further testing. I am giving the laboratory permission to bill my insurance company.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I UNDERSTAND THE RISKS, SIDE EFFECTS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL OF MY QUESTIONS WERE ANSWERED

Patient or legal guardian signature: ________________________________ Date: _______________ Time: __________

Patients name printed: ____

Witness signature: ____ Date: _______________ Time: __________

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the Patients/Guardian questions.

Physician signature: ____ Date: _______________ Time: __________