Patient Name: _____ Date: _____ Time: _____

I hereby authorize Dr. _____, ("physician") and such assistants as may be selected to treat the following condition(s): _____

A. The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr. _____, and I understand the nature of the procedure to be (check where applicable):

- ☐ Flexible Sigmoidoscopy (insertion of tube into rectum/colon) with possible biopsy (tissue sample)
- ☐ Colonoscopy with possible biopsy (tissue sample) or polypectomy (polyp removal) (insertion of tube into rectum/colon)
- ☐ EGD (Esophagogastroduodenoscopy (EGD or Upper Endoscopy) (Insertion of tube into esophagus/stomach/duodenum) with possible biopsy (tissue sample) / cautery /dilation (stretch narrowed area).
- ☐ PEG (Percutaneous Endoscopic Gastrostomy) tube replacement. A non-surgical technique for replacement of a feeding tube.
- ☐ Hemorrhoid Therapy: **A.** Infrared Coagulation (IRC) (An anoscope is put into the rectum to allow the hemorrhoids to be seen. A heat producing instrument is placed on the hemorrhoid tissue & a small controlled tissue burn is made.) **B.** Anorectal Hemorrhoid Ligation (Bands are placed on tissue)

B. It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

***Contrast Radiographic Studies (Barium Enema or GI series)** ***For PEG: Surgical Gastrostomy (feeding tube)**
***Observation (not to do the procedure)** ***For Sclerotherapy / Banding / IRC: Surgery and/or medication**

C. I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

- Bleeding (increase if biopsy, polypectomy or sphincterotomy is performed)
- **Perforation (tear a hole inside possibly requiring surgery to be performed). Possible colostomy (opening of a portion of the colon through the abdominal wall to its skin surface to direct to fecal stream through a colostomy bag)**
- **IRC (Bleeding or pain could lead to the need for antibiotics, transfusions, hospitalization or surgery)**
- **Anorectal Hemorrhoid Ligation (Could lead to severe pain, if treatment is too close to anal verge or possible ulceration at banding sites)**
- **Splenic Rupture**
- **Aspiration (fluid entering the lungs)**
- **Missed polyps / lesions or abnormalities**

D. Blood Thinning Medications: The risks of stopping, not stopping or restarting blood thinning medications too soon are inherent risks of any procedure, which can result in the following: **Stroke** **Heart Attack** **Bleeding** **Clotting** **And even death**
Any blood thinning medications that you are taking should be discussed with your physician prior to your procedure. **You are RESPONSIBLE for following your prescribing Physician's instructions regarding blood thinning medications. You are responsible for understanding your medications including their usage, risks and benefits of holding / continuing & restarting your medications.**

E. I have been told if the procedure is not performed, what may happen to me is: **The condition listed above may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding / Tumor / or Growth / Disease)**

F. It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the procedure or any other procedure commenced.

G. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest, etc., that are attendant to the performance of any surgical procedure. I have been made aware that during a procedure, growths, lesions or abnormalities may be missed. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s). If any new symptoms occur or old symptoms persist, I am aware that I should seek additional, immediate medical therapy.

H. I consent to the administration of anesthesia and the use of such anesthetics as may be deemed advisable by the physician or anesthesiologist responsible For this service to me. The anesthesiologist is not necessarily a physician as named above. Benefits and risks of anesthesia have been explained. Risks include, but are not limited to changes in heart rate, breathing and/or blood pressure or inflammation at site of injection.

I. I consent to the retention or disposal of any tissue or parts which be removed.

J. I am aware that the admission of other observers to the Operating and/or Procedure room(s) may occur, as approved by my physician.

K. If my physician or member of Advanced Endoscopy & Surgical Center's staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood for the human immunodeficiency virus (HIV) and hepatitis.

L. I have informed Advanced Endoscopy & Surgical Center & my Physician of **ALL** changes in my medical history up to the day of my procedure.

M. I certify that I have read and fully understand the above consent to operate procedure(s): that the explanations therein referred to were made to me by Dr. _____, and that the statements requiring insertion or completion were filled in. I am in agreement with all of the above unless checked ☐ No If checked No, then the procedure(s) cannot be completed at AESC until further discussion and agreement between the Physician and patient takes place, and a new informed consent is completed.

_____ _____ _____
Signature of Patient or Other Person Responsible **Relationship if Patient Unable to Sign** **Witness Signature**

PHYSICIAN'S CERTIFICATION

I, Dr. _____, certify that I have explained procedure(s), the attendant risks and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

_____ _____
Physician's Signature **Date**

(For AESC Use Only) *****AFTER 30 DAYS UP-DATE: ( ) PATIENT REMAINS IN AGREEMENT, WITH NO CHANGES*****

_____ _____
Patient Signature **Witness Signature**

_____ _____
Physician Signature **Date**

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(REVISED: 06/2016)

PATIENT LABEL

ENDOSCOPY CONSENT