DIGESTIVE HEALTH CENTER

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request ____ as my physician, and such associates, technical assistants and other health care providers as he/she may deem necessary, to treat my condition which has been explained to me as: ____

I understand that the following surgical, medical and/or diagnostic procedure(s) are planned for me and I voluntarily consent and authorize these procedures:

- ❒ Esophagogastroduodenoscopy with possible biopsy and/or polypectomy and/or dilation
- ❒ Colonoscopy with possible biopsy and/or polypectomy and/or dilation
- ❒ Flexible Sigmoidoscopy with possible biopsy and/or polypectomy and/or dilation
- ❒ Other:____

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment. I understand that no warranty or guarantee has been made to me as to result or cure.

I have either seen the educational video or had this procedure explained to me. Just as there may be risks and hazards in continuing my present condition without treatment, there may also be risks hazards related to the performance of the procedure. The benefits, alternatives and risks of the procedure have been discussed with me and I have had the opportunity to ask questions about my condition and procedure. These risks of the procedure (s) include but are not limited to: pain, bleeding, perforation, infection, cautery burn, missed lesion or cancer, drug reaction, cardiac arrhythmia, sore throat, phlebitis, antibiotic therapy, pancreatitis, hypoxia, need for hospitalization and/or blood transfusion, hypotension, aspiration, paralysis and even death.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I feel I have been given sufficient information to give informed consent for my scheduled procedure.

__________ __________ ____

Date Time Patient and/or Legal Guardian's Signature

__________ __________ ____

Date Time Witness

Physician Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the surgery/procedure and have allowed the patient/responsible adult to ask questions.

____ ________________________

Physician Signature Date/Time