Consent for Endoscopic Procedures, Other Special Procedures, and Sedation or Analgesia

Patient __________________________________________ Date _________________________

I hereby authorize Dr. ________________________ to perform the following procedure(s):

- [ ] upper endoscopy
- [ ] colonoscopy
- [ ] sigmoidoscopy
- [ ] biopsy
- [ ] polypectomy
- [ ] dilation
- [ ] cautery
- [ ] pouchoscopy
- [ ] Bravo test
- [ ] conscious sedation
- [ ] MAC
- [ ] Pillcam placement
- [ ] other __________________________

The general nature of the anticipated procedure, the medically accepted alternative procedures and the potential risks inherent in the proposed treatment have been explained to me. I understand such risks and I consent to the procedure. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

I voluntarily consent to the proposed procedure at this facility. It has been fully explained to me that during the course of the procedure, it is possible that unforeseen conditions including but not limited to bleeding, infection, drug reactions, perforation, post-polypectomy burn syndrome and missed lesions could occur and may necessitate additional or different procedures than those described to me, including surgery. I authorize and request that my physician, his/her assistants or his/her designees, perform such additional procedures as are deemed necessary. I consent to be transferred to a hospital in the event that my condition warrants such a transfer.

I consent to the administration of sedation or analgesia via topical, local injection or intravenous routes as deemed advisable and administered by my physician. I understand that sedation or analgesia bears some risk of injury, allergic reaction or rarely death even when administered by the most competent physician.

For the purpose of advancing medical education, I consent to the admittance of approved observers to the procedure room. I consent to the photographic documentation of the findings for medical purposes, provided the pictures or descriptive text accompanying them does not reveal my identity.

I consent to the pathologic evaluation of any tissue, which is removed in accordance with the medical staff rules and regulations of the Endoscopy Center of Connecticut.

I consent to care at the Endoscopy Center of Connecticut with the knowledge and understanding that while under the care of the Endoscopy Center of Connecticut any and all Advanced Directives I may have to limit resuscitation will be noted, but not honored. In the event of a medical emergency requiring resuscitation, I will be resuscitated without limitations and transferred to the hospital, at which time my Advanced Directives will be made known to the receiving physician. Living Will □ Yes □ No If yes, location of Living Will __________________________

If no, does patient want info? □ Yes □ No

(Initials) _______

I consent to care at the Endoscopy Center of Connecticut with the knowledge that this facility is owned exclusively by the physicians of the Gastroenterology Center of Connecticut and that I have voluntarily chosen this facility over similar facilities in the area. (Initials) _______

Patient Signature __________________________________________ Date _________________________

If the patient is a minor or unable to sign, complete the following:

Patient is a minor _______ years of age or unable to sign because _______________________________

Closest relative or Legal Guardian Signature _______________________________

Witness to patient or Guardian signature _______________________________

I have discussed with the patient the risks, benefits and alternatives to the proposed procedure(s).

Physician Signature _______________________________ rev/Jan 13