

## Procedure Consent

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I authorize the provider selected below to perform the following test/treatment/procedure: (name of test/treatment/procedure in the patient's own words): \_\_\_\_\_

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- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ravi Mallavarapu, MD | <input type="checkbox"/> Srinivas Kalala, MD | <input type="checkbox"/> Richard Manfready, MD |
| <input type="checkbox"/> Kavan Patel, MD      | <input type="checkbox"/> Taha Ashraf, MD     |  |

Name of the test/treatment/procedure in medical terms (health care worker to fill in):

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Colonoscopy  | <input type="checkbox"/> Esophagogastroduodenoscopy | <input type="checkbox"/> Flexible Sigmoidoscopy      |
| <input type="checkbox"/> Paracentesis | <input type="checkbox"/> Liver Biopsy               | <input type="checkbox"/> Endoscopic Ultrasound (EUS) |

**By signing this form, I understand and acknowledge that I have been informed of the following:**

1. My medical condition has been explained to me by my provider.
2. The reasons for and the purpose of the recommended test/treatment/procedure has been explained to me.
3. The nature of the recommended test/treatment/procedure has been explained to me.
4. The risks and benefits of the recommended test/treatment/procedure have been explained to me.
5. The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
6. All of my questions about the recommended test/treatment/procedure have been answered to my satisfaction.

**By signing this form, I acknowledge and understand:**

1. That the practice of medicine is not an exact science, and that no guarantees have been made to me as to the results of the test/treatment/procedure. I also understand that complications may occur which are beyond the control of the provider.
2. That unforeseen conditions may arise during the test/treatment/procedure. I agree that additional, necessary procedures may be performed based on intra-procedural findings and the provider's clinical judgement. Possible procedures with a reasonable likelihood of needing to be performed have been discussed with me.
3. The risks, benefits and alternatives to the type and method of anesthesia/sedation have been explained to me.  
**Risks may include but are not limited to:** Nausea, vomiting, sore throat, dizziness, pain at the injection site, risk of dental injury (chipping, cracking, loosening of teeth, crowns or other dental work), allergic reactions, breathing difficulties (which may require airway assistance or insertion of an airway device), laryngeal spasm, pulmonary aspiration, temporary nerve damage, heart attack, stroke, severe allergic reaction (anaphylaxis) or death.

