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DigestiveHealthCenter.com

DIGESTIVE HEALTH CENTER

Procedure Consent

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

_____

□ Ravi Mallavarapu, MD □ Srinivas Kalala, MD □ Richard Manfready, MD

□ Kavan Patel, MD □ Taha Ashraf, MD

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

□ Colonoscopy □ Esophagogastroduodenoscopy □ Flexible Sigmoidoscopy
□ Paracentesis □ Liver Biopsy □ 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 my arise during the test/treatment/procedure. I agree that additional, necessary procedures may be performed based on intraprocedural 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.

Benefits include: Pain relief and comfort during the procedure, allowing it to be performed safely and effectively. Alternatives to anesthesia, such as proceeding without anesthesia have been discussed.

My questions about the anesthesia/sedation have been answered to my satisfaction, and I consent to the administration of such anesthesia/sedation medications as may be considered necessary or advisable by my physician.

- That the provider may remove tissue or biopsies during the test/treatment/procedure.
- That I may be given a substance during an x-ray to make my body tissue easier to see.
- That pictures or videos of my test/treatment/procedure may be taken, if my provider thinks it is needed for medical reasons.
- That someone may watch or help with my test/treatment/procedure for medical teaching purposes.
- That if my provider thinks I need **blood or blood products** for medical reasons, **it will be given.**

I have read the above consent form. I understand the Risks, Benefits, and Alternatives of the test/treatment/procedure. I authorize my provider to perform the recommended test/treatment/procedure.

Patient Signature	Date	Time
Witness Signature	Date	Time

This section is for a minor patient, or patient without legal rights to sign the consent. Signature below must be from a person who has legal right to consent for the patient.

Signature of Legal Representative to Patient	Date	Time
Relationship to Patient		
Witness Signature	Date	Time