CONSENT FOR ENDOSCOPY PROCEDURES

DOCTOR(S):_____
has/have discussed my medical problem with me and has/have explained in lay terms the following procedure(s) to be undertaken in the course of my treatment:_____

_____

_____

- ☐ Flexible sigmoidoscopy, Possible Biopsy, Possible Polypectomy
- ☐ Colonoscopy with Possible Biopsy and Polypectomy, Heater Probe Coagulation and/or Sclerotherapy of Bleeding Sites
- ☐ Esophagogastroduodenoscopy With Possible Biopsy, Polypectomy, Esophageal and Pyloric Dilitation, Heater Probe and/or Sclerotherapy of Bleeding Sites
- ☐ Endoscopic Retrograde Cholangiopancreatography With Possible Stone Extraction, Papillotomy, Stent Placement, Biopsy and Polypectomy, Nasobiliary Tube Insertion.
- ☐ Percutaneous Endoscopic Gastrostomy (PEG)
- ☐ Esophageal Dilation ☐ Enteroscopy ☐ Bronchoscopy
- ☐ Nasal Endoscopy ☐ Laryngoscopy ☐ PEG Tube Exchange
- ☐ Other:_____

1. I have been fully informed and understand the potential benefits, risks and side effects of this care and also the likelihood of achieving goals related to this procedure. Any potential problems that might occur during recuperation have been explained to me. I have also been informed about reasonable alternatives and the risk of not receiving this procedure.
2. My physician has fully informed me of and I understand the potential risks and the possibility of complications, and medically acceptable alternatives to the above-described procedure(s), and I understand that I may refuse to undergo such procedure(s). These risks and complications include:
   *Pneumothorax or Collapsed lung, Air Embolus
   *Possible soreness, inflammation, or phlebitis of the intravenous ("IV") site.
   *Injury to the digestive tract by the instrument which may result in perforation of the bowel wall with leakage of intestinal juices into body cavities. If this occurs, surgery to close the leak and/or drain the region may be necessary.
   *Bleeding which, if occurs, is usually a complication of biopsy, polypectomy, or dilation. Management of this complication may consist of only careful observation or may require a blood transfusion, or possibly a surgical operation for control.
   Other risks include drug reactions and complications from other associated diseases which you may have, such as a stroke or heart attack. You should inform your physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with very low frequency. Any of the complications could lead to death.
3. I understand the risks and consent to the administration or transfusion of blood or blood components to me during my procedure and/or its related treatment whenever deemed necessary by those physicians attending me, with no warranties made in connection with such blood or blood components.
4. If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request the physician and/or his other associate(s) to take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
5. I consent to the proposed procedure(s) by the above physician(s) and (their) associates. I consent to the disposal by hospital authorities of any tissue or parts which may be removed in connection with my procedure(s). Tissues and/or organs, no longer needed for diagnostic purposes, may be used and/or photographed for research and educational purposes at JFK Medical Center, and it's teaching facilities or for publication in an article related to medical research for the purpose of medical education.
6. I consent to the taking of photographs or recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician(s) and to the admittance of qualified observers to the procedure room as determined by the hospital.
7. I have been made aware and acknowledge that the practice of medicine is not an exact science and that no guarantee or assurances have been made to me regarding expected outcomes.

I have read and understand all of the above. I have had an opportunity to ask questions concerning my planned procedure(s) and my questions have been answered to my satisfaction.

_____	_____	___/___
Signature of Patient	Print Name	Date Time

If patient is unable to consent or is a minor, complete the following: Patient is unable to consent because_____

_____

_____	_____	___/___
Signature of Authorized Representative	Print Name	Date Time

_____
Relationship to Patient

_____	_____	___/___
Witness (Signature &Title)	Print Name	Date Time

PHYSICIAN'S CERTIFICATION

NAME OF PHYSICIAN/SURGEON: _____

I hereby certify that the patient or one authorized to act on his/her behalf:

1. Has been fully informed by me or my physician associates, in lay terms understandable to the patient, the nature of the procedure(s), the medically acceptable alternative(s) to treatment, including refusal, and the consequences and risks to the patient inherent to or associated with the procedure(s); and the likelihood of the patient achieving his/her goals.
2. Has authorized the performance of the procedure(s).

_____	_____	___/___
Physician's Signature	Print Name	Date Time

Patient Identification/Label