Garden State Endoscopy & Surgery Center

200 Sheffield St. Suite 101
Mountainside, NJ 07092
Tel: 908-241-8900 / Fax: 908-241-8933

SCA Health

Patient Name: _____ DOB: _____

Procedure: _____ Performing MD: _____

PROCEDURE CONSENT

I hereby authorize (name of Performing MD)_____and/or such assistant(s) as may be selected by him to treat the condition(s) which appear indicated by the diagnostic studies already performed. The procedure(s) necessary to treat my condition(s) has/have been explained to me and **I** understand the nature of the procedure(s) to be:

☐ **Colonoscopy/ Anoscopy/ Flexible Sigmoidoscopy:** the visualization of the large intestine with a flexible video or fiberoptic telescope with the possible removal of polyp(s), possible biopsy or cautery of any suspicious tissue, and/or control of any bleeding site, possible marking of the intestine to relocate suspicious sites possible ligation, excision, and/or sclerosis of hemorrhoids.

☐ **Upper Endoscopy:** the visualization of the esophagus, stomach, and duodenum with a flexible video or fiberoptic telescope, removal of polyp(s), biopsy or cautery of any suspicious tissue, injection therapy or rubber band ligation to control any bleeding sites, and dilation (stretching) of narrow areas.

☐ **Percutaneous Endoscopic Gastrostomy (PEG):** upper endoscopy and insertion of a feeding tube through the anterior wall of the abdomen.

☐ **Removal / Replacement of feeding tube (PEG)**

☐ **Paracentesis:** A trocar or large needle is inserted into the peritoneal cavity of the abdomen under local anesthesia to remove ascetic fluid

☐ **Other Procedure:** _____

1. Consent to photograph/videotape: I understand that during the course of the procedure(s), photograph or videotape recordings may be taken of the procedure or specimen. They will be maintained as part of the facility and/or physician's confidential record. I consent to the aforementioned providing that my confidentiality is not compromised.

2. I consent to the administration of sedation/anesthesia by or under the direction/supervision of Dr. **<Performing MD>**_____

3. I recognize that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedure(s) than set forth in paragraph 1. **I** therefore authorize and request that the above-named physician, his assistant(s), or his designee(s) perform such procedure(s) as are in the exercise of professional judgment necessary and desirable. If there is any question that **I** might be pregnant, I will allow urine pregnancy testing to be performed prior to my procedure. The authority granted under this paragraph 4 shall extend to treating all conditions that require treatment and are not known to the physician at the time the procedure(s) is/are commenced.

4. I have been made aware of the risk(s) and consequences that are associated with the procedure(s) described in paragraph 1. These include ***bleeding, perforation, and adverse reactions to medications and missed lesions.***

5. I have been informed of the other risk(s) such as severe blood loss, infection, cardiac or respiratory arrest, etc., that are attendant to any procedure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the

procedure(s), and I have further been informed of the alternative(s).

6. I have been made aware that a consultant/medical student or fellow or representative of a medical company might be present in the room during my procedure.

7. I hereby give permission to the Center to dispose of any tissue removed in the course of the procedure(s) in accordance with policy.

8. I understand that I should not drive for twenty-four (24) hours following my procedure. I also understand that in the event of cardiac arrest or respiratory arrest or other life-threatening situation during my admission, the center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at Garden State Endoscopy and Surgery Center. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care

9. I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, expect as specified by law.

10. I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, no test is 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or a misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray, and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will discuss these options with you.

_____ _____

PATIENT / AUTHORIZED PERSON DATE

_____ _____

WITNESS DATE

I hereby certify that the risks and benefits of the proposed procedure/treatment as well as the alternatives have been explained to the patient or responsible other.

_____ _____

SIGNATURE: PHYSICIAN DATE