CENTRAL JERSEY AMBULATORY SURGICAL CENTER
511 Courtyard Dr., Hillsborough, NJ 08844
Tel: (908) 895-0001 Fax: (908) 685-8833

Patient Label

INFORMED ENDOSCOPY CONSENT

I hereby authorize Dr. _____,("physician")and such assistants as may be selected to treat my condition(s) procedure to be (check where applicable)

A. The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr._____ , and I understand the nature of the procedure to be (check where applicable):

- ☐ Flexible Sigmoidoscopy (insertion of tube into rectum/colon) with possible biopsy (tissue sample)
- ☐ Colonoscopy (insertion of tube into rectum/colon) with possible biopsy, polypectomy (polyp removal), injection therapy, or control of bleeding
- ☐ Infrared Coagulation of Hemorrhoids (IRC) (insertion of probe into rectum to coagulate hemorrhoids)
- ☐ Esophagoscopy Gastroscopy Duodenoscopy (EGD) with possible biopsy (tissue sample) /cautery / dilation (stretching of a narrowing) / (Insertion of tube into throat, stomach and duodenum)
- ☐ Other: _____

B. It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

- Contrast Radiographic Studies (Barium Enema or GI Series) – X-Rays
- Observation (not to do the procedure)

C. I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

- **Bleeding (increased risk if biopsy or polypectomy is performed) may require a blood transfusion.**
- **Perforation (a hole torn inside possibly requiring a procedure or surgery to be performed: the presence of extensive diverticulosis are more prone to complications)**
- **Infection (possibly requiring intervention, such as antibiotic treatment, surgery or other treatments)**
- **Aspiration (fluid entering the lungs)**
- **Post Polypectomy Burn Syndrome**

D. I have also been told that if the procedure is not performed, what may happen to me is: **The condition(s) may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding / tumor or growth / disease).**

E. It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the operation or other procedure commenced.

F. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest – etc., that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and procedure is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. **Even the best experienced physicians can miss abnormal growths possibly related to poor prep, spasm, diverticular disease, etc.**

G. I consent to the retention or disposal of any tissue or parts, which may be removed.

H. I also authorize the presence of observers, as considered appropriate or advisable by the surgeon or his/her associate or assistant according to the center policy and in accordance with HIPAA and the state law.

I. If my physician or a member of the center staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood, including but not limited to the human immunodeficiency virus (HIV) and hepatitis.

_____ _____

Witness to Signature — Signature of Patient or other person responsible

_____ _____

Witness to Signature — Relationship when patient is unable to sign or is a minor

PHYSICIAN'S CERTIFICATION

I, Dr. _____ , certify that I have explained the specified operation(s) or procedure(s), the attendant risk and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

_____ _____

Physician's Signature — Date

Revised 11/11/10