Surgical Consent Form

Patient Name_____

Proposed Procedure(s)_____

Physician_____

Consent to Procedure, Administration of Anesthetics and Rendering of other Medical Services

1. The Endoscopy Center maintains personnel and facilities to assist your physician in their performance of various special diagnostic or therapeutic procedures. These procedures may all involve risks of unsuccessful result, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the procedure; the expected benefits or effects of such procedure; and the available alternative methods of treatment and their risks and benefits. Except in cases of emergency, procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or refuse any proposed procedure any time prior to its performance.

3. Your physician(s) have recommended the procedure (s) set forth above. Upon your authorization and consent, the procedure (s) set forth above, together with any different or further procedures which in the opinion of the supervising physician may be indicat3ed due to an emergency, will be performed on you, the patient. The procedure(s) will be performed by the physician named above (or in the event of an emergency, causing his/her inability to complete the procedure a qualified substitute physician, together with associates and assistants, including anesthesiologists and pathologists to whom the physician may assign designated responsibilities. The pathologist is hereby authorized to use his or her discretion in disposing of any tissue removed from your person during the procedure (s) set forth above.

4. Your signature below constitutes your acknowledgement that (1) you have read and agree to the foregoing; (2) that the procedure set forth above has been adequately explained to you by the above named physician; (3) That you authorized and consent to the performance of the procedure; (4) that you authorize and consent to the administration of anesthesia for the said procedure; and (5) that you have read the Patient's Bill of Rights.

5. ADVANCE DIRECTIVE-I understand that even though the physicians and staff of the Endoscopy Center respect my rights to participate in decisions regarding my heath care, the policy of the center is that all patients undergoing procedures will be considered eligible for life-sustaining emergency treatments.

6. I have made arrangements to have a responsible adult drive me home.

7. I consent to the admittance of observers to the procedure room and to the recording and televising of the procedure (s) to be performed including appropriate portions of my body, whether or not necessary or advisable in the treatment of my condition. All pictures remain the property of the Endoscopy Center.

8. In the event of an accidental exposure of my blood or bodily fluids to a physician or employee of the center, I consent to the testing for HIV and Hepatitis.

9. In the event of an emergency or urgent situation, I consent to the transfer and/or admission to a nearby acute care facility for continuity of care.

10. _____ Yes, my doctor/nurse can talk to my family/responsible adult. _____No, I don't want my doctor/nurse to talk to my family/responsible adult.

11_____ I consent to the nurse leaving a message on my voicemail if I don't answer my phone for a post-op phone call.

DATE: _____ SIGNATURE_____

If signed by other than patient, indicate the relationship_____

DATE: _____ WITNESS_____

PHYSICIAN' STATEMENT

I CERTIFY THAT I HAVE EXPLAINED TO THE PATIENT, TO THE EXTENT REASONABLE AND CONSISTENT WITH CURRENTLY ACCEPTABLE STANDARDS OF PRACTICE, THE NEED AND NATURE OF THE NAMED PROCEDURE (S), CONSEQUENCES AND COMMON COMPLICATIONS, HOPED FOR ACHIEVEMENT AND OUTCOME, PLUS ANY PERTINENT ALTERNATIVES TO THE PROCEDURE(S).

DATE: _____ SIGNATURE_____MD/DO