**Authorization for and Consent to**

**Surgery / Procedure**

*TO THE PATIENT*: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I consent to allow my physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and such other assisting physicians and surgical personnel as requested by my physician to perform the following surgery or procedure:

\_\_\_ **UPPER ENDOSCOPY**- an examination of the esophagus, stomach, and duodenum with possible dilatation (tubes or balloon are used to stretch narrowed areas), biopsy (a sampling of cells or tissue/polyps removed for testing/analysis), cauterization or injection therapy (the use of heat or chemical agents applied to a bleeding source)

\_\_\_ **COLONOSCOPY**- an examination of all or the major part of the colon with possible biopsy (a sampling of cells or tissue/polyps removed for testing/analysis), cauterization or injection therapy (the use of heat or chemical agents applied to a bleeding source) or dilatation (tubes or balloon are used to stretch narrowed)

\_\_\_ **FLEXIBLE SIGMOIDOSCOPY**- an examination of the anus, rectum, and last part of the colon with possible biopsy (a sampling of cells or tissue/polyps removed for testing/analysis), cauterization or injection therapy (the use of heat or chemical agents applied to a bleeding source) or dilatation (tubes or balloon are used to stretch narrowed)

\_\_\_ **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My physician has explained to me the nature and purpose of the surgery/procedure that will be performed. I understand 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 this surgery or procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the surgery or procedure may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the surgery or procedure.

My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives to the surgery or procedure. The potential risks or complications of this procedure include infection; aspiration; adverse reaction to medication; infection, phlebitis, and/or nerve injury related to the IV catheter; injury to organs; bleeding; perforation; cardio/respiratory complications; and death. Patients with previous abdominal/pelvic surgery and those with extensive diverticulosis may be at higher risk for complications. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result. Other risks specific to this procedure may include \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Teeth and/or dental prosthetics (such as dental implants, veneers, caps, crowns, and bridges) may become loose, broken, or dislodged, especially if loose or in poor repair regardless of the care provided. By signing this consent, you are acknowledging that neither your physician, anesthesia provider, nor the facility will be responsible for any dental damage or repair costs.

I understand that there are risks with any surgery or procedure, and it is impossible for the physician to inform me of every possible complication.

In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the surgeries or procedures to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer’s representative, for technical assistance, or a student, for continuing education, to be in attendance during my surgery or procedure if the situation arises.

I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist and the like are independent practitioners exercising their independent clinical judgment. They are not employees or representatives (agents) of the surgery center. I understand that anesthesia services are being provided by Easton Anesthesia and I will sign a separate consent form for those services.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the surgery or procedure.

I have been given an explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives and I enter into this contract to consent to the surgery or procedure freely. I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction.

I attest that I am 18 years of age or older, my judgment is not impaired by any legal or illegal substance, and I am signing this consent of my own free will and have not been forced by any person to consent to this procedure. The undersigned certifies that he/she has read the foregoing and the patient, the patient’s legal guardian, or the patient’s authorized representative accepts its terms.

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Patient / Patient’s Representative Signature / Relationship Date/Time

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Witness Signature Date/Time

**Physician Statement**

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the surgery/procedure and have allowed the patient/responsible adult to ask questions.

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Physician Signature Date/Time

**Translation Services**

 \_\_\_\_\_\_ Translation services have been utilized. This consent has been verbally translated into (insert language) for the benefit of the patient/patient’s representative who understands this language better than English.

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Translator’s ID Number and/or Name Translator’s Signature (If Onsite) Date/Time