FORM - CONSENT Surgery-Procedure

University Endoscopy Center

Authorization for and Consent to Procedure

(with sedation/anesthesia)

I consent to allow my physician, ____________________________________, and such other assisting physicians and personnel as requested by my physician to perform the following procedure:

□ a Esophagogastroduodenoscopy □ a Colonoscopy □ a Flexible Sigmoidoscopy □ a Liver Biopsy
and/or □ a Other ______________________.

My physician has explained to me the nature and purpose of the 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 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. 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 contractors with me and not employees of the Center.

□ Anesthesia services are being provided by AmSurg Cincinnati Anesthesia and I will sign a separate consent for those services

□ I understand that conscious sedation will be provided for this procedure given by the Registered Nurse under the direction of the physician. I understand that conscious sedation involves additional risks and hazards but I request the use of sedation for the relief from pain during the procedure (s). I understand that certain complications may result from the use of conscious sedation including respiratory problems or drug reaction.

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, but not limited to: bleeding, perforation, infection, adverse reaction to medication, nausea and vomiting, injury to organs, dental /gum/lip trauma, prolonged recovery, and cardio/respiratory complications. In a small percentage of patients, a failure of diagnosis or a mis-diagnosis may result.

I understand that there are risks with any surgery or procedure, including extremely rare potential for serious harm, cardiac arrest, and death. I understand it is impossible for the physician to inform me of every possible complication.

I understand that surgical and/or diagnostic procedures performed on me at the Center will be done on an outpatient basis and the Center does not provide 24 hour patient care. If my attending practitioner or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Center to a hospital or other health care facility, I consent and authorize the employees of the Center to arrange for and effect the transfer.

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.

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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 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 the opportunity to ask questions about the procedure that will be performed. I have been given 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. ____________ (patient initial)

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.

____ _________________________________
Patient Signature Date/Time

____ _________________________________
Patient Representative Signature / Relationship Date/Time

____ _________________________________
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.

____ _________________________________
Physician Signature Date/Time