Paramus Endoscopy, LLC dba
Surgical & Endoscopy Center of Bergen County

Endoscopy Consent

Patient name:	Date of birth:
MRN:	Date of procedure:
Procedure:	Endoscopist:

I hereby authorize Dr ______________ 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) is listed above and has/have been explained to me. I understand the nature of the procedure(s) to be:

GASTROSCOPY / UPPER ENDOSCOPY (Esophagogastroduodenoscopy): A lighted tube (endoscope) is passed through the mouth into the esophagus, stomach and first part of the small intestine (duodenum) for evaluation. Abnormal tissue will be biopsied (sampled) and polyps (growths) may be removed. If the esophagus is narrow it may be stretched (dilated). If foreign bodies are present they may be removed. If bleeding is seen, injection or thermal therapy or rubber band ligation will be used to control bleeding.

COLONOSCOPY / ANOSCOPY / FLEXIBLE SIGMOIDOSCOPY: The visualization of the large intestine with a flexible video / fiberoptic-telescope with the possible removal of polyp(s), possible biopsy or cautery of any suspicious tissue, chromoendoscopy (dye spray) , and / or control of any bleeding site, possible marking of the intestine to relocate suspicious sites possible ligation, excision, sclerosis, and / or infrared coagulation of hemorrhoids. If the colon is narrow it may be stretched (dilated).

ENDOSCOPIC ULTRASOUND: Upper Endoscopy or colonoscopy, as above, with the passage of an ultrasound probe into the intestines, possible mucosal resection, fine needle aspiration or fine needle biopsy, biopsy or polypectomy.

If my physician is providing the sedation for the procedure, I understand I may be given fentanyl and/or versed injected into the bloodstream to produce a semi-conscious state, reduce anxiety and improve tolerance of the procedure. A topical anesthetic may be used for an upper endoscopy with or without sedation. The risks include progression to a deeper state of sedation, depressed breathing and damage to blood vessels. Alternative techniques for sedation have been explained to me

1. The applicable procedure has been explained in terms understandable to me, in which the explanation has included:

a. The nature and extent of the procedure to be performed;
b. The risks involved, including those, even though unlikely to occur, involving serious consequences;
c. Alternative procedures and methods of treatment;
d. The danger and possible consequences of such alternatives (including no procedure or treatment);
e. The estimated period of incapacity and the estimated period of convalescence (assuming there are no complications);
f. The expected consequences of the procedure upon my future health.

2. I have asked all of the questions I thought were important in deciding whether or not to undergo treatment or diagnosis. Those questions have been answered to my satisfaction.

3. I understand no assurance can be given that the procedure will be successful, and no guarantee or warranty of success or cure has been given to me,

4. I further authorize and request my physician and his/her associates, assistants, and appropriate Center personnel to perform such additional procedures which in their judgment are incidentally necessary or appropriate to determine my diagnosis/treatment.

5. I hereby authorize the above named surgeon to use his discretion in the retention, preservation or disposal of any tissue or member consistent with the Center's policies and procedures.

6. I understand that during the course of the operation, photographs, moving pictures and/or other visual recordings may be taken of the procedure or specimen and maintained as part of the Center's or the physician's confidential record.

7. I consent to the presence of manufacturer's representatives and other observers to the operating or treatment room if approved by my physician.

8. I hereby authorize the Center and all doctors rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered (including copies of my record). A photostatic copy of this authorization shall be considered to be as effective and valid as the original.

9. I further consent to the drawing of blood and testing for exposure to hepatitis A, B, C and to the human immunodeficiency viruses in the event that an individual at the Center is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential except 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.

11. Risks of the procedures above include, but are not limited to, bleeding, infection, adverse drug reaction, cardiac arrest, respiratory arrest, splenic injury or bleeding or perforation (making a hole) in the intestine or any other organ. If perforation were to occur, this could require emergency surgery, possibly with a colostomy (bag). Endoscopic procedures are not perfect tests and some lesions, even some cancers, can be missed with these examinations. In a small percentage of cases, a failure of diagnosis or a misdiagnosis may result.

12. This procedure was added to the schedule today as a medically necessary procedure. Surgery in this ASC, Paramus Endoscopy, LLC dba Surgical & Endoscopy Center of Bergen County, is suitable for this patient. Applicable only if patient is added to schedule today.

____
Signature_Patient or Legal Representative

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Signature_Witness

PHYSICIAN'S STATEMENT OF INFORMED CONSENT
I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to the above named procedure(s)/operations(s)
_________________________________ Signature_Physician Date and Time