CONSENT FOR SURGERY OR SPECIAL PROCEDURES FOR TREATMENT OR DIAGNOSIS

PATIENT____ **CHART NUMBER**________________________

I authorize the following surgical or special procedure to be performed on ____
(MYSELF, OR NAME OF PATIENT)

by and/or under the direction of Dr. ____

Surgical/special Procedure to be performed: GASTROINTESTINAL ENDOSCOPY

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly. If any abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilatation).

The procedure has been explained to me by Dr. ____and the risks, benefits, complications and alternative treatment options, including, but not limited to, those listed below were discussed.

BENEFITS: ____

RISKS: Injury to the lining of the digestive tract by instrument, which may result in perforation of the wall and leakage into body cavities; if this occurs, surgical operation to close the lad and drain the region is often necessary. **Bleeding,** if it occurs, usually is a complication of biopsy, polypectomy, or dilation; management of this complication may consist only in careful observation or may require blood transfusions or possibly a surgical operation for control. Medication given in the vein to help you relax during the procedure may cause **vein irritation (phlebitis) or pain, allergic reaction, cardio respiratory depression or possible arrest. Sore throat and rectal irritation** may occur after these procedures.

COMPLICATIONS/SIDE EFFECTS: ____

ALTERNATIVE TREATMENTS OPTIONS: ____

I also consent to the performance of operations and procedures in addition to or different from these now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or those physicians assisting him/her may consider necessary or advisable in the course of the operation. I further authorize my physician to transfer me to a contracted hospital, should an emergency, requiring clinical intervention(s) beyond the scope of services provided by Nashville General Hospital, arise during the course of this procedure.

I acknowledge that no guarantee or assurance has been given by anyone as to the result that may be obtained from this procedure.

Note to patient/responsible party: you may refuse to consent for any items listed 1-5 by crossing the item out and initialing.

1. **I consent to** the administration of anesthesia, to be given by such person as designated by my physician. The technique, possible complications and results of such anesthetic procedure have been explained to me. I am therefore aware of the risks and consequences, such as trauma, nerve paralysis, infections, hypersensitivity reactions to anesthetic drugs, harmful or unexplained reactions to vital organs or anesthetics, and even death. I understand the risks, benefits, and alternatives to anesthesia.
2. **I authorize** and consent to the transfusion of blood and blood components to me as necessary during my surgery and such additional transfusions as may be deemed advisable in the judgment of the attending physician, his associates or assistants. I understand that blood transfusions and/or blood derivatives are not always successful in producing the desired results and that there exists the possibility of ill effects. I understand the risks, benefits, and alternatives to the transfusion of blood and blood components.
3. **I consent to** the photographing or televising/videotaping of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.
4. **I consent to** the presence of a company sales representative(s) that may bring necessary equipment for some surgical procedures appropriate to the surgery being done. The company sales representative is only there as a technical support person and will not be part of the surgical team.
5. **I consent to** the disposal by hospital authorities of any tissues or parts, which may be removed.

Nashville General Hospital maintains personnel and facilities to assist your physicians and surgeons in doing various surgical operations and other procedures for diagnosis and treatment. These operations and procedures all involve **RISKS OF COMPLICATIONS, SERIOUS INJURY OR EVEN DEATH**, from both known and unknown causes. Except in cases of emergency or exceptional circumstances, these operations and procedures are therefore not performed unless the patient has had an opportunity to discuss them with his physician. You, as a patient, have the right to consent to or refuse any operation or special procedure that is proposed by your doctor(s).

I acknowledge that all blank spaces or crossed out items on this document have been either completed or crossed off prior to my signing.

I hereby sign this consent with the understanding of the possible benefits, risks, and possible alternatives involved.

PHYSICIAN/PROCEDURALIST'S SIGNATURE:_______________________ DATE:__________ TIME: _______ ❑ AM ❑PM

PATIENTS SIGNATURE:______________________________ DATE:__________ TIME: _______ ❑ AM ❑PM
(BY PATIENT OR BY HIS/HER NEAREST RELATIVE OR HIS/HER LEGAL GUARDIAN IF THE PATIENT IS A MINOR OR PHYSICALLY OR MENTALLY UNQUALIFIED)

WITNESS:____ DATE:__________ TIME: _______ ❑AM ❑PM
(WITNESS TO PATIENTS SIGNATURE)

WITNESS:____ DATE:__________ TIME: _______ ❑AM ❑PM
(WITNESS TO PATIENTS SIGNATURE)

2nd witness only required where patient cannot sign (e.g. oral consent)

Place patient label here