Space Coast Endoscopy Center

PREVENTIVE HEALTH. PERSONAL CARE.

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/EGD (Esophagogastroduodenoscopy) – The examination of the esophagus, stomach, duodenum and jejunum with possible biopsy/polypectomy. Possible dilation of narrowed areas with balloons or tubes, injection therapy, variceal ligation, electrocautery and application of clips.

_____ Colonoscopy – The examination of the anus, rectum, and/or pelvic area and all or the major part of the large intestine and/or ileum with possible biopsy/polypectomy. Possible dilation of narrowed areas with balloons, injections therapy, electrocautery and application of clips.

_____ Flexible Sigmoidoscopy – The examination of the anus, rectum, and/or pelvic area and last part of the large intestine with possible biopsy/polypectomy. Possible dilation of narrowed areas with balloons, injections therapy, electrocautery and application of clips.

_____ Endoscopic Ultrasound with possible fine needle aspiration and/or biopsy.

_____ Pelvic/Rectal Exam Consent – (for Colonoscopy and Sigmoidoscopy) I understand the Rectal portion of a Pelvic Examination will be performed by my physician as part of my procedure and in some instances will include an examination of other pelvic organs if medically necessary. I understand that a Pelvic Examination is defined as a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

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; drug reaction; phlebitis; nerve injury; injury to organs; bleeding; perforation; cardio/respiratory complications; nausea and vomiting; and prolonged recovery from anesthesia; brain damage, paralysis, stroke, or 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.

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.

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.

I consent to the photographing of my procedure(s), to be included in my medical records for the purpose of care and treatment. This may include appropriate portions of my body, provided no identity is revealed by the pictures and/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 AmSurg Rockledge FL Anesthesia, LLC and I will sign a separate consent form for those services.

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

In compliance with Florida law, your pathology test may include DNA analysis for the purpose of supporting an accurate medical diagnosis. If DNA testing is necessary, all information collected and utilized will be kept confidential as required by law and will not be disclosed to unauthorized agents.

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.

Patient / Patient's Representative Signature / Relationship

Date/Time

Witness Signature (Staff)

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

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.

Translator's ID Number and/or Name

Translator's Signature (If Onsite)

Date/Time