Capital Health

Consent for Operative Therapeutic, Invasive or Diagnostic Procedure
Side 1 of 2

Patient name: _____
Date of Birth: _____

PART I: Consent or Refusal for Surgery or Procedure

1. I authorize
practitioner(s) Dr. Simonian, Dr. Bhatia, Dr. Dhillon, Dr. Protano, Dr. Weinstein
to perform the following surgical and/or medical procedures **(use full names no abbreviations):**
ESOPHAGOGASTRODUODENOSCOPY WITH BIOPSY, CAUTERY AND POLYP REMOVAL IF NEEDED. THE RISKS INCLUDE BUT ARE NOT LIMITED TO BLEEDING,INFECTION AND/OR PERFORATION OF THE ESOPHAGUS, STOMACH, OR UPPER INTESTINE.
2. I authorize the following to be implanted during the above-named procedure: **(general description)**
_____
_____
3. I understand that the procedure(s) will be performed at Capital Health by or under the supervision of the attending physician. He/She is authorized to use services of other independent healthcare professionals including members of the Capital Health medical staff as he/she deems necessary.
4. I understand that Capital Health's residents, students and trainees may be participating in my care, under appropriate supervision. I understand that in certain circumstances it may be necessary for a health care industry representative to be present in the operating room to consult with the operative team.
5. I understand that during the surgical procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedures than those described above. I authorize and request that the surgeon, his/her assistants, or his/her designees perform such surgical procedures(s) as are necessary or desirable in the exercise of their professional judgment.
6. I authorize representatives from Capital Health to examine or photograph portions of my body, use dismembered tissue for education, medical research or developmental purpose(s), and dispose of tissue which may be removed, as necessary for my diagnosis/treatment.
7. The attending surgeon and/or practitioner has fully explained to me the nature and the purpose of the procedure(s), the benefits, possible alternative methods of diagnosis and treatment, the risks involved, the possibility of complications, the foreseeable consequences of the procedure(s) and the possible results of non-treatment. I acknowledge that no guarantee or assurance has been made as to the results of the procedure(s).

I have read and understand this consent statement. I have been given the opportunity to ask the questions I have about the procedure(s) to be performed and they have been answered to my satisfaction.

_____ _____ _____
Patient/Authorized Representative Signature Date Time

I certify that I have explained the risk, benefits, and alternatives of this treatment to the patient or his/her representative and have answered all of his/her questions.

_____ _____ _____
Practitioner Signature Date Time

Capital Health

Consent for Operative Therapeutic, Invasive or Diagnostic Procedure
Side 2 of 2

Patient name: _____
Date of Birth: _____

PART II:

Consent for Transfusion of Blood or Blood Products

1. I understand that if it is necessary to receive a blood transfusion and/or human source product (including, but not limited to, bone, tissue, tendon, bone graft, etc), the blood and/or product will be supplied by sources available to the hospital and tested in accordance with national and regional regulations. I understand the benefits of receiving a blood transfusion and/or human source product. I also understand that there are risks associated with the transfusion of blood and/or the use of human source products, including but not limited to allergic, febrile, and hemolytic transfusion reaction, and transmission of infectious diseases such as Hepatitis and AIDS (Acquired Immune Deficiency Syndrome).
2. I understand the alternatives to transfusion such as autologous donations (donation of the patient's own blood), directed donation (donation on behalf of the patient by friends and relatives) and intra-operative salvage (use of the patient's own blood recovered during the procedure if the condition, time, and the surgical procedure allow). I understand that these options, by themselves, may not be sufficient to preserve my life.

3. **I consent** to the transfusion of blood components and/or the use of human source products, and agree to hold harmless the hospital, its physicians, and all members of its staff from any liability resulting from the administration of blood and/or human source products.

_____ _____ _____
Patient/Authorized Representative Signature Date Time

I certify that I have explained the risk, benefits, and alternatives of this treatment to the patient or his/her representative and have answered all of his/her questions.

_____ _____ _____
Practitioner Signature Date Time

Refusal of Blood or Blood Products

4. I request that no blood or blood products be administered to me during this hospitalization, notwithstanding its assistance to preserve life or promote recovery. I release the licensed healthcare practitioner, his/her assistants, the hospital and its personnel from any responsibility whatsoever for any untoward results due to my refusal to permit the use of blood or blood products.

_____ _____ _____
Patient/Authorized Representative Signature Date Time

PART III: Conscious Sedation

1. I understand that conscious sedation may be used for this procedure. The risks, benefits of and alternatives (as well as the risk and benefits of these alternatives) to conscious sedation were discussed with me, including the risks and benefits of no sedation, and I authorize use of conscious sedation.

_____ _____ _____
Patient/Authorized Representative Signature Date Time

_____ _____ _____
Practitioner Signature Date Time