EGD INFORMED CONSENT

Law requires that your written consent be obtained for any contemplated surgery or various other medical procedures. As a result, you are being requested to sign this form to confirm that you have received all desired information concerning your surgery or other medical treatment under consideration to enable you to determine of your own free will whether or not to undergo the surgery or other medical procedure(s). The purpose is to inform you and not to alarm you. Please read this form carefully and ask about anything you do not understand.

Dr. Yuhas and Staff have fully informed me concerning the contemplated surgery or medical procedure known as a ***Esophagogastroduodenoscopy with possible biopsies or polypectomy using IV sedation***.

The reason(s) for the proposed surgery are: ***visibly inspecting and obtaining samples or biopsies as needed to diagnose and treat my condition***.

Although no specific result has been guaranteed, is expected to accomplish the following: ***to visibly inspect and obtain samples or biopsies as needed to diagnose and treat my condition***.

Any surgery or procedure has potential complications among which are anesthetic reactions, blood clots forming in the legs and traveling to the lungs, death, infection, bleeding to the extent requiring blood transfusions, and injury to other organs or structures such as: ***perforation, abdominal bloating, cramping, gas, and reaction to medications***.

Other approaches to my treatment have been discussed and include: ***X-rays, scans, barium enema with subsequent colonoscopy or exploratory surgery***.

I understand if I am to have conscious sedation, in advance of administration of any sedating medication, the physician has explained to me and /or my family as appropriate, the risks and benefits of sedation.

I wish to proceed with the proposed surgery or procedure and accept the risks and consequences as noted above. I acknowledge that Dr. Yuhas has answered all my questions, and I authorize him to proceed with the proposed surgery and consent to: the use of photography and or video during the surgery as deemed advisable by Dr. Yuhas and/or his assistants; analysis and disposal of tissue(s) removed; and administration of anesthesia as deemed proper. It may be necessary to have regulatory surveyors, sales representatives, and/or students present in the OR suite under the surgeon's discretion.

I recognize that complications may occur and that unforeseen conditions may be encountered, I authorize and consent to such additional services as may be deemed reasonable or appropriate. It is understood by me that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of this surgery or other medical procedures.

_____ _____ _____

Patient or Legal Representative Signature *Date/ Time* *Relation to Patient*

_____ _____

Print Patient or Legal Representative Name *Witness Signature and Date*

NA	YES	TIME OUT
	□	Two patient identifiers verified
□	□	Correct site / side marked
	□	Consent obtained
	□	Correct procedure
□	□	Correct patient position
□	□	Diagnostic images available
□	□	Appropriate equip/fluids/ATB available
	□	Med, Allergy History reviewed
	□	Educated on prevention of infection

Date/Time_____ Signature_____

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or their legal representative. I have answered all questions fully, and I believe that the patient or legal representative fully understand what I have explained.

_____

Physician Signature and Date