65th street GI Office-Based Surgery

within the offices of
**Yaffe Ruden & Associates**
201 East 65th Street
New York, New York 10065

# Gastroscopy Consent Form

Dr. Yaffe has explained to me the nature and purpose of this procedure and has described that part of my body which will undergo this procedure.

I have received preoperative instructions; both written and verbal. I am aware that are alternatives to this procedure, including X-Rays or surgery or avoiding the procedure altogether. I have been given the opportunity to ask questions about the risks and benefits of the alternative options.

I understand that there may be risks associated with any endoscopic examination, such as: Medication Reaction; Lack of Awareness lasting several hours; Swelling of a Hand or Arm following injection of sedative medications. More serious complications may also occur, including Bleeding after a biopsy or removal of a polyp or other growth in your stomach. A Perforation of your Intestine is also a possible complication, which may require immediate surgery.

I also understand that a small percentage of polyps and other tumors may not be seen during a gastroscopy.

I am aware that no guarantee or assurance as to the results of the procedure have been made and I have been told that no guarantee of results could be made. By signing this consent, I agree that all the foregoing has taken place to my satisfaction.

I also understand that I will not be able to drive a vehicle, or perform any activities requiring rapid reflexes, for at least 4 (four) hours after the conclusion of the procedure.

Therefore, I authorize my physician to perform this procedure along with any necessary pre-procedure or post-processor treatment.

If appropriate, I will read and sign a separate consent form to receive sedation or anesthesia from a Board Certified Anesthesiologist.

At times, the physicians may ask for permission to have an observer in the Endoscopy Suite. If there is such an observer, and if the reason for their presence has been explained to me, I give my permission for their presence in the endoscopy suite during my procedure.

I authorize my doctor to disclose complete information concerning his medical findings and treatment for the undersigned, from the initial consultation until the conclusion of such treatment, to those individuals who in my doctors sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Name: _____
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**DATE:** _____