65th Street GI Office-Based Surgery - 201 East 65th Street - New York, NY 10021 - 212-879-4700

CONSENT TO PERFORM ENDOSCOPIC PROCEDURE

I, _____ have discussed with _____ the nature and purpose of a procedure, which is to be performed on (myself) . The name of the procedure has been described to me as:

_____

The doctor explained to me, to my satisfaction, the nature and purpose of this procedure and has described that is a visual examination of the lining of my

_____

Some treatments such as dilation of a narrowing, injection, ligation or removal of objects/small tumors may be done. Additionally, treatments of bleeding blood vessels or ulcers with heat or epinephrine may occur.

I understand that the procedure time usually lasts 15-30 minutes and the recovery time will usually be 30-60 minutes. I have received preoperative instructions - both written and verbals. I am aware of alternatives to the procedure including Xrays _____

I also have the option of receiving no treatment. I have been given the opportunity to ask questions about the risks and benefits of alternative options.

I understand that there may be risks associated with any endoscopic examination, included but not limited to: medication reaction, lack of awareness lasting several hours, swelling of a hand or arm following injection of sedative medications. More serious complications may occur including bleeding after a biopsy or removal of a polyp or other growth in my _____ In very rare instances, death may occur.

I understand that a small percentage of polyps or tumors or other findings may not be seen during the examination.

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 understand that I will not be able to drive a vehicle or perform any activities requiring rapid reflexes for at least _____ after the conclusion of the procedure.

Therefore, I authorize my physician to perform this procedure along with any necessary pre-procedure or post-procedure treatment. I will read and sign a separate consent form to receive sedation (anesthesia) from a board certified anesthesiologist.

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

Confirmed by

_____ _____ _____

_____

WITNESSED BY

_____ _____ _____