ADVANCED GASTROENTEROLOGY OF SOUTH FLORIDA, PA
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Gastroenterological Procedures and Sedation Administration Consent Form

Gastrointestinal (GI) endoscopy allows your physician to see the lining of the colon and upper GI tract using flexible instruments containing a light and video chip at the end of them. At the time of the exam, polyps may be removed and small tissue samples (biopsies) may be taken for analysis. Photographs of the GI tract may be taken for documentation purposes.

Procedures

_____ **Esophagogastroduodenoscopy** (EGD)**:** Examining the esophagus (swallowing tube), stomach, and the beginning of the small intestine. This may include biopsy, dilation (stretching out a narrowing), or treatment of bleeding.
_____ **Colonoscopy:** Examining all or a portion of the large intestine. This may include biopsy, removal of polyps, dilation, or treatment of bleeding.
_____ **Flexible Sigmoidoscopy:** Examining the lower portion of the large intestine. This may include biopsy, removal of polyps, dilation, or treatment of bleeding.

Risks

I have been made aware of the risks and consequences associated with the procedure including but not limited to: perforation or tear, bleeding, medication reaction, heart attacks, heart rhythm disturbances including stoppage of the heart, breathing difficulties, neurological complications including stroke or seizure, and death. It has been explained to me that during the course of the procedure unexpected events may happen that might need further treatment including additional procedures, operations, and medications (e.g. anesthesia and blood transfusions). I have been informed of my patient rights regarding Advance Directives. I authorize no guarantee has been made to me regarding the results of the procedure including the risk of missing a polyp, cancer, or other abnormalities.

Conscious Sedation Consent

I acknowledge that I have been given an explanation of the procedure for which I am scheduled. Prior to or during the procedure, I may be given conscious sedation. Conscious sedation is a state achieved by injecting medicine into a vein that will make me drowsy and reduce my memory of the procedure. In addition to the risks of the procedure, conscious sedation may be associated with loss of consciousness, slowed breathing, or failure to provide adequate pain relief. If the sedation is not enough to allow the procedure to go on, the procedure may be postponed and alternate choices discussed. I understand that conscious sedation is part of the management plan for my procedure. I am also aware there are alternatives to conscious sedation. I hereby consent to the administration of medication for the purpose of conscious sedation. I understand that these medications will be ordered by my physician and will be administered by a registered nurse or other qualified individual. I understand that I may not drive, drink alcohol, or sign legal documents until the next day. I have been advised I need to be accompanied by a responsible adult upon discharge from this facility.
Today, Federal and State legislation provide guidance to health care professionals with respect to the proper release of confidential health care information.

If you have an escort with you today, do you want that person present when the physician talks to you after your procedure? ❑ Yes ❑ No

We call our patients the next business day after a procedure to check on their progress.

May we call you at home? ❑ Yes ❑ No

May we call you at work? ❑ Yes ❑ No

If you are not home:

May we leave a message with any household member? ❑ Yes ❑ No

May we leave a message on your answering machine? ❑ Yes ❑ No

Consent

I certify I have read and understand the content of this informed consent document and acknowledge advance receipt of Advanced Gastroenterology of South Florida, P.A. Patient Rights and Responsibilities. I also certify all my questions and concerns regarding the procedure, its risks, benefits, and alternatives have been explained to my satisfaction. I hereby authorize the physician noted above and/or such assistants as may be selected by him/her to perform the above procedure.

_____ _____

Patient Signature /POA/Guardian Date