



SAND LAKE
SURGERY CENTER

7477 Sand Lake Commons Boulevard
Orlando, Florida 32819

GASTROSCOPY CONSENT FORM

Under Florida law, you have both the right and the responsibility to make decisions concerning healthcare. The physician shall provide you with the necessary information, but, as a member of the healthcare team, it is essential that you enter into the decision making process. This form has been designed to document your informed consent to the invasive procedure(s) that you have discussed with your physician.

Authorization and Nature of Procedure(s): I request and hereby authorize:

Dr. _____ and/or associates to perform a procedure(s) known as a fiber-optic esophagogastroduodenoscopy, possible mucosal biopsy, possible esophageal dilation, possible polypectomy, possible tumor, or vascular ectasia ablation, possible foreign body removal, possible ulcer cauterization or injection, possible stent placement, possible placement of capsule, possible placement of pH monitoring device, and/or possible ligation of esophageal varices. This procedure(s) requires an empty stomach and I have been instructed when to stop eating and drinking. I understand that I may receive medication prior to the procedure(s), which may include throat spray and intravenous sedation. I understand that the procedure(s) is done with a flexible tube passed through my mouth to examine the esophagus, stomach and duodenum. Various diagnostic and therapeutic procedure(s) discussed above may be performed. Biopsies (tiny bits of tissue) may be taken, placement of pH monitoring device, narrow areas may be dilated (stretched), polyps may be removed, and tumors, abnormal blood vessels, or abnormal mucosa (lining of the intestine), may be treated with various cauterizations. If tissue is recovered, it may be examined by a Pathologist.

Risks and Complications: I understand that there are risks and possible complications involved with this procedure(s). I understand the risks to be bleeding, perforation of the wall of the esophagus, stomach or duodenum, infection and cardiopulmonary complications including aspiration of stomach contents into the lungs, abnormal heart rhythm and depressed breathing functions.

I acknowledge and understand that complication from the procedure(s) may result in the need for further surgical intervention.

I acknowledge and understand that because no two human beings are alike, the potential risks and complications may vary from person to person. For that reason, I understand the prediction of complications and risks cannot be accurately made.

I understand that unusual complications, not normally expected and beyond those mentioned above, can occur during this procedure(s), but that such complications are so infrequent that they are not usually explained to patients. I do not wish to have any further explanation given to me, even though I have been advised that I am entitled to such further explanation, if I so desire.

No Guarantee or Assurance: I understand that, because differences exist between human beings, both in their anatomy and in terms of their response to treatments, my doctor cannot give me any guarantees as to the outcome of this procedure(s) or whether or not I will encounter any risks or complications, whether known or unknown, associated with this procedure(s).

Additionally, because no test is 100% capable of locating lesions, I understand that this test has a definite rate of missing abnormalities, albeit small. Recognizing that there is a possibility of a failure to diagnose, further testing may be warranted at some time and I must report any persistent or unusual symptoms to my physician to better guide in the detection of lesions that conceivably may be missed.

Alternative Treatment/Procedure(s): I have been informed of medically acceptable alternatives and therapy and the benefits, risks and complications of those alternatives and therapies. The complication of x-ray can include reaction to either dyes or tubes, which are placed into the body. The risk of surgery, if warranted, includes risk of bleeding, infection, damage to organs and the risk of increased anesthesia required. The choice of no procedure(s) incurs the risk of missed diagnosis and/or worsening of the condition.

Other Operations and/or Procedure(s): I understand that, during the course of this procedure(s), the performance of other operations or procedure(s), in addition to or different from those now contemplated, may become necessary in the medical judgment of the above-named physician and/or his associates. I authorize such physician and/or his associates to perform such other procedure(s) as he/she deems necessary, within the exercise of his/her sound medical judgment.

Attendance of Other Health Care Providers: I understand that physicians, nurses, or other persons in training programs and currently assigned to the facility may observe in this procedure(s), according to the instructions and under the supervision of the physician and/or association named above.

Sedation: Procedural sedation describes the state that allows patients to tolerate procedure(s) while maintaining adequate cardiopulmonary function and the ability to respond purposely to verbal command and/or physical stimulation. The benefits of procedural sedation are the ability to undergo the study without undue anxiety, stress and without compromising the quality of the study. The risks of procedural sedation include drowsiness, dizziness, weakness, nausea, constipation, allergic reaction, temporary loss of short-term memory, hallucinations, a significant increase or decrease in blood pressure, elevated heart rate, hypoxia, respiratory depression, cardiac arrest and possible damage to vital organs or death. If general anesthesia is anticipated, then a separate consent will be initiated for anesthesia.

Tissue Disposition: I authorize the appropriate disposal of any body tissue removed during the course of the above procedure(s) after the same has been examined by the Pathologist.

Advanced Directives: These are not honored at Sand Lake Surgery Center. In the event of an emergency or life-threatening situation, advanced cardiac life support procedures will be constituted in every instance and the patient will be transferred to a higher level of care.

Consent to Transfer: I understand that the procedure to be performed on me at the Facility will be done on an outpatient basis and that the Facility does not provide 24-hour care. If my physician or any other duly qualified physician in his/her absence shall find it necessary or advisable to transfer me from the Facility to a higher level of care, I consent and authorize the employees of the Facility to arrange for and affect the transfer to _____ hospital.

Photographs / Videotapes: I authorize my physician and SAND LAKE SURGERY CENTER to photograph and/or videotape my procedure(s) at the discretion of my physician. I understand that the photograph(s) / videotape will be used only for the purpose of medical study/research, education and/or documentation for my medical record.

Opportunity for Further Information: I understand that other physicians may recommend a different procedure(s) and that I am free to see the advice of other physician(s) as I might choose. Prior to signing this document, I have taken the time to consider whether I wish to ask further questions of my physician or whether I desire a second opinion. I understand that, by signing this document, I have voluntarily agreed to undergo the procedure(s) described above. I understand that my signature indicates that I do not desire any further opinions from other physicians, nor do I wish to ask any further questions.

Opportunity to Read Documents: I acknowledge that prior to signing this document, I have had the opportunity to read this document and that I thoroughly and fully understand it.

Permission for Blood Draw - In the event of an employee or physician sustaining an accidental exposure to blood or other bodily fluids by needlestick, splash or scalpel injury, for example, I consent to have my blood drawn for blood-borne diseases to include, but not limited to, hepatitis and HIV. I understand that my physician will inform me of the test results after being discharged from the facility.

I HAVE HAD SUFFICIENT OPPORTUNITY TO DISCUSS THE MEDICAL CONDITION AND THE PLANNED PROCEDURE(S) AND ANESTHESIA/SEDATION WITH THE ABOVE-NAMED PHYSICIAN AND/OR ASSOCIATES AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND BOTH SIDES OF THIS FORM, THE MEDICAL CONDITION AND THE PLANNED PROCEDURE(S) AND I HAVE ADEQUATE INFORMATION UPON WHICH TO BASE AN INFORMED CONSENT. DO NOT SIGN IF YOU HAVE ANY FURTHER QUESTIONS.

I HAVE ADVANCED DIRECTIVES

PATIENT / LEGALLY AUTHORIZED SIGNATURES

_____/_____
Date Time

Patient Signature

Witness

Parent / Legal Guardian (if patient a minor)

Witness Signature (signature / phone consent)

Translator Language Translated

Patient Unable to sign because: _____

PHYSICIAN DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's questions and, to the best of my knowledge, I feel this patient has been adequately informed and has consented.

Physician Signature

Date