San Antonio Gastroenterology Endoscopy Centers

Name:	MRN:
DOB:	Gender:
Provider:	DOS:

Authorization for and Consent to Procedure

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I consent to allow my physician,

❑ *Dr. John J. Alvarez*	❑ *Dr. Joseph E. Johnson*	❑ *Dr. Belinda Ramirez*
❑ *Dr. Eddie Flores*	❑ *Dr. Robert Narvaez*	❑ *Dr. Steven R. Ramos*
❑ *Dr. Kevin J. Franklin*	❑ *Dr. Richard L. Otero*	❑ *Dr. Antonio Serna*
❑ *Dr. Ernesto Guerra, Jr.*	❑ *Dr. Mohammad Taheri*	

and such other assisting physicians and personnel as requested by my physician to perform the following procedure:

❑____ UPPER ENDOSCOPY (an examination of the esophagus, stomach, and duodenum with possible biopsy)

❑____ COLONOSCOPY (an examination of all or the major part of the colon with possible biopsy/polypectomy)

BIOPSY/POLYPECTOMY (a sampling of cells or tissue/polyps removed for testing/analysis)

❑ ____ FLEXIBLE SIGMOIDOSCOPY (an examination of the anus, rectum, and last part of the colon)

❑ ____ CAUTERIZATION OR INJECTION THERAPY (the use of heat or chemical agents applied to a bleeding source)

❑ ____ DILATION (tubes or balloons are used to stretch narrowed areas of the esophagus, stomach, or intestine)

❑ ____ GASTROSTOMY TUBE REMOVAL (the removal of a feeding tube in the stomach)

❑ ____ SCLEROTHERAPY

❑ ____ ESOPHAGEAL BANDING

❑ ____Other _____

My physician has explained to me the nature and purpose of the procedure that will be performed. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives to the procedure. The potential risks or complications of this procedure include infection; aspiration; adverse reaction to medication; infection, phlebitis, and/or nerve injury related to the IV catheter; dental trauma, including fracture or loss of teeth, bridgework, dentures, crowns and fillings, and laceration of the gums or lips; injury to organs; bleeding; perforation; cardio/respiratory complications; and death that are attendant to the performance of any surgery/procedure. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result. Other risks specific to this procedure may include:

_____

_____

_____

I understand that there are risks with any procedure, and that it is impossible for the physician to inform me of every possible complication.

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I understand that diagnostic procedures performed on me at the Center will be done on an outpatient basis and the Center does not provide 24 hour patient care. If my attending practitioner or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Center to a hospital or other health care facility, I consent and authorize the employees of the Center to arrange for and effect the transfer.

In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the surgeries or procedures to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, to be in attendance during my surgery or procedure if the situation arises.

I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist and the like are independent contractors with me and are not employees of the Center.

I understand that anesthesia services are being provided by **San Antonio Gastroenterology Associates** and I will sign a separate consent form for those services.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the procedure.

I have been given the opportunity to ask questions about the procedure that will be performed. My questions have been answered to my satisfaction. I have been given an explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives and I enter into this contract to consent to the procedure freely.

The undersigned certifies that he/she has read the foregoing and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____ Date: _____ Time:_____
Patient / Patient's Representative Signature / Relationship

_____ Date: _____ Time: _____
Witness Signature

Physician Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the procedure and have allowed the patient/responsible adult to ask questions.

_____ Date: _____ Time:_____
Physician Signature