安健腸胃肝膽專科診所
NEWTOWN GASTROENTEROLOGY

CONSENT TO OPERATION, SPECIAL PROCEDURES, OR TREATMENTS

1. In order to treat (my) (the patient's) medical condition(s) I consent to the performance upon (me),_____, for the following operation, procedure, or treatment_____, biopsy or polypectomy if needed with moderate sedation or anesthesia The practitioner(s) reasonably anticipated to be actively involved in such operation, procedure or treatment (not including residents) is:_____ **M.D.**
2. If I have a DNR/DNI in place I consent to the suspension of the DNR/DNI during the above-named operation, procedure or treatment and during the immediate perioperative period, including any time spent in the recovery room**.** **YES NO**
3. I understand that " Sedation and Analgesia," a form of anesthesia with monitoring of vital signs, may be needed so that I (the patient) may be comfortable and still during the operation, procedure or treatment listed above, and I consent to the administration of Sedation and Analgesia by or under the direction of the above-named physician and/or such associates and assistants as may be designated by him/her. I understand that Sedation and Analgesia allows for quick recovery and expeditious discharge. Complications, including the need to progress to Deep Sedation and/or airway management (including intubation), are extremely rare in this form of anesthesia and relate more to the patient's condition than specifically to the administration of Sedation and Analgesia. I also authorize changes from Sedation and Analgesia to another form of anesthesia as is considered necessary for my/the patient's well-being during the operation, treatment or procedure listed above.
4. The physician has explained to me the potential benefits, the likelihood of success, the reasonably foreseeable risks (infection, bleeding, making a hole[perforation]), possible complications and consequences which are, or may be associated with the above operation, treatment or procedure and with Sedation and Analgesia, if applicable, and I willingly assume them; also the probable duration of incapacitation, potential problems related to recuperation, if any, and the medically significant alternative methods for (my) (the patient's) care and treatment (including no treatment) have been explained to me before making this decision(attach additional pages if necessary).
5. I understand that the explanation that I have received may not be exhaustive and that other risks and consequences may arise.
6. I acknowledge that I have received no guarantee with respect to the benefits to be realized or the consequences of the above operation, procedure, treatment, and of "Sedation and Analgesia".
7. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph 1. I therefore authorize and request that the above-named physician(s), his/her associate(s) and/or assistant(s) perform such procedures or change my status from outpatient to inpatient as they deem necessary in the exercise of their reasonable medical judgment.]
8. I acknowledge that I have read this document (and any attached pages) in its entirety and that I fully understand it.

*Date Signed: _____/_____/_____ Time: _____am/pm

_____ OR _____

Patient's Signature **Signature and relationship to patient of person authorized to consent for patient**

_____ _____

Witness's Signature **Print Name and Title of Witness**

_____ _____

Interpreter Signature (if applicable) **Print Name and Title of Interpreter**

PHYSICIAN'S CERTIFICATION

I hereby certify that I, or my designee, explained to the patient, or person authorized to consent for the patient, the nature of the proposed operation, procedure, treatment listed on the reverse side and the nature of Sedation and Analgesia, if applicable. In addition to advising of medically significant alternative modes of treatment, if any, including no treatment. I have explained, in layperson's terms, the potential benefits, the likelihood of success, reasonably foreseeable risks, complications and consequences, including probable duration of incapacitation and potential problems related to recuperation, which are, or may be associated with the operation, procedure, treatment, and those that are or may be associated with Sedation and Analgesia, if applicable. The Patient, or person authorized to consent for the patient, has indicated his or her understanding, has consented to the operation, procedure, treatment and to the administration of Sedation and Analgesia, if applicable, has had an opportunity to ask questions, and has stated that no further explanation was desired.

_____M.D. Date: _____/_____/_____ Time: _____am/pm

Physician/s Signature