BETHESDA ENDOSCOPY CENTER, LLC

AUTHORIZATION FOR PERFORMANCE OF OUTPATIENT PROCEDURES

(1)I _____ authorize the following procedure(s) performed by Dr. _____.
(Name of Patient)

(Patient's initials)_____/_____Colonoscopy with possible biopsy and/or polypectomy with cautery

(Patient's initials)_____/_____Upper Endoscopy (EGD) with possible biopsy and/or polypectomy with cautery or dilatation

(Patient's initials)_____/_____Colonoscopy and Upper Endoscopy (EGD) with possible biopsy and/or polypectomy with cautery or dilatation

(Patient's initials)_____/_____Flexible Sigmoidoscopy with possible colonoscopy and biopsy and/or polypectomy with cautery

(Patient's initials)_____/_____Other _____

(2) It has been explained to me that during the course of the procedure, 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, his assistants, or his designees perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to remedying all conditions that require treatment and are not known at the time the procedure is commenced.

(3) I understand that there are risks and hazards related to the procedure. The following are some but not all, of the risks I have been told can occur: a) perforation of bowel or esophagus with leakage into the body cavity, (b) bleeding, (c) infection, (d) reactions to medication, and (e) stomach cramping and gas following the procedure. Any of these complications can result in extended hospitalization, blood transfusion and/or emergency surgery. Death is extremely rare, but remains a remote possibility. I understand the procedure accuracy is not perfect and findings or conditions can be missed on occasions. Alternative diagnostic tests to the procedure include barium x-rays or computerized tomographic colography but the accuracy is less and any abnormalities cannot be treated. If I decide not to have this procedure then colon polyps or gastrointestinal cancer may go undetected and appropriate treatment delayed.

(4) I understand that sedation involves additional risks but I request the use of sedation for the relief from pain during the procedure(s). I understand that certain complications may result from the use of sedation including respiratory problems or drug reaction.

(5) Explanation of my procedure, benefits, common foreseeable risks, and alternatives have been presented to me. I have had the opportunity to have my questions answered to my satisfaction by Dr. _____.

(6) I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of the treatments or examination.

(7) I consent to photographs of my gastrointestinal tract during this procedure.

I certify that I have read and fully understand the above consent to the procedure that the explanations referred to therein have been made, and that all blanks requiring insertion or completion were filled in or stricken before I sign.

Date:_____ Patient's Signature or Responsible Agent:_____

Time:_____ Witness:_____

IT IS UNDERSTOOD THAT IF ANY OF THE FIRST FIVE ITEMS ARE STRICKEN BY THE PATIENT, INFORMED CONSENT IS NOT IN EFFECT AND THE PROCEDURE CANNOT BE PERFORMED.

PHYSICIAN CONFIRMATION OF INFORMED CONSENT

I have explained to the patient (or legally responsible agent), _____ his/her condition, the proposed procedure, other methods of treatment, and the possible common complications.

Date:_____ Physician's Signature:_____