260 Patchogue-Yanphank Road Suite C, East Patchogue, New York, 11772 | (631) 307-9181

Patient Name: **Test Test 1**
Physician: **No Provider**
Procedure: **Upper GI endoscopy**

INFORMED PROCEDURE CONSENT

I authorize **No Provider** and any assistant(s) deemed necessary to perform a **<scheduled procedure>** with possible biopsy and/or polypectomy.

I have had the opportunity to ask the doctor questions about the procedure, all of which have been answered to my satisfaction.

Prior to my consent I have been made aware of certain risks, hazards, complications and consequences, including but not limited to; bleeding, perforation, injury to internal organs such as the spleen requiring hospitalization, transfusion of blood products and/or surgery with loss of organ. Aspiration which may result in bronchitis or pneumonia that are associated with the above operation, procedure(s), as well as a possible alternative modes of treatment.

It has been explained to me that during the course of a procedure unforeseen conditions may be revealed that necessitate an extension of the original procedures(s) or different procedure(s) than those set forth above. I therefore authorize and request that the above named endoscopist, his associates and/or assistants perform such surgical procedures as are necessary and desirable in the exercise of their professional judgment. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the above physician at the time the procedure commenced.

I have also been informed that there are other risks, such as severe loss of blood, infection, cardiac arrest, etc. that are attendant to the performance of any endoscopic procedure. I am aware that the practice of medicine is an not exact science, that lesions or other conditions may not be visualized in the performance of the endoscopic procedure, and I acknowledge that no guarantee or assurances have been made to me concerning the discovery of all possible lesions or conditions and concerning the results to the above operation, treatment or procedure.

I further consent to administration of such drugs, infusion or any other treatment, injections or procedures deemed necessary or desirable in the judgment of the medical staff.

I further consent to disposal by GSBEC authorities, in accordance with accustomed practice, of any tissue which may be removed.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE CONSENT, THAT THE EXPLANATIONS REFERRED TO THEREIN WERE MADEIN LAYMEN'S LANGUAGE, AND THAT ALL BLANKS WERE COMPLETED AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

<Patient Sig>
Patient Name: Test Test 1

<Witness_Sig>

I HEREBY CERTIFY THAT PRIOR TO THE PATIENT'S CONSENT I HAVE EXPLAINED THE NATURE, PURPOSE, BENEFITS, RISK, AND ALTERNATIVES TO THE PROPOSED TREATMENT, HAVE

OFFERED TO ANSWER ANY QUESTIONS AND HAVE FULLY ANSWERED ALL SUCH QUESTIONS. I BELIEVE THAT THE PATIENT/RELATIVE/GUARDIAN FULLY UNDERSTANDS WHAT I HAVE EXPLAINED AND ANSWERED.

<Physician Sig>
