GI CONSENT TO ENDOSCOPY AND/OR COLONOSCOPY

PATIENT: ______________________________________ DATE: ________________ TIME: ____________

1. I authorize the following to be performed upon myself (check all that apply and initial):

◯ **Colonoscopy** with possible biopsy and/or polypectomy to include the possible use of electrocautery. This examination involves the passage of a long, flexible instrument through the rectum to view the lining of the entire large bowel with moderate sedation.

◯ **Esophagogastroduodenoscopy (EGD**) with possible biopsy. This exam involves the passage of a long, flexible instrument through the mouth to view the esophagus, stomach, and the duodenum with moderate sedation.

◯ **Flexible Sigmoidoscopy** with possible biopsy and/or polypectomy with possible use of electrocautery. This examination involves the passage of a shorter, flexible instrument through the rectum to view the lining of the lower large bowel with possible moderate sedation.

This procedure(s) will be performed and/or directed by Dr. David Tenembaum.

I confirm that the physician has informed me of the following:

a. The nature, purpose and possible risks of the procedure(s) as well as alternative methods of treatment. Risks include but are not limited to bleeding, puncture of gastrointestinal tract and side effects of the medication used.
b. That the explanation that I have received is not exhaustive and that other, more remote risks may arise.
c. That I acknowledge that I have received no guarantees or assurances from anyone as to the results that may be obtained, including the possibility of undetected lesions such as polyps or cancer.
d. That I understand and do not desire further explanation.

2. I consent to the use of sedation, as may be necessary and advisable to achieve moderate sedation. I understand that moderate sedation may involve some risk even though administered in a careful manner. I further understand that a patient should not drive, operate equipment, or drink alcoholic beverages for at least 24 hours after sedation.

3. I consent to the performance of procedures in addition to or different from those now planned, whether or not arising from presently unforeseen conditions, which the above named doctor and/or his associate may consider necessary or advisable in the course of the procedure.

4.I consent to photographing during the procedure for documentation in my medical record and that these photographs may be used by the physician or the associate for the advancement of medical education. I understand that my identity will not be revealed outside of my personal medical record.

Patient Signature: ___________________________________ Date: ____________ Time: ____________

Witness: ____ Date: ____________ Time: _____________

INFORMED CONSENT FOR ANESTHESIA SERVICES

1. Hereby authorize Eastside Alliance Medical Associates (EAMA) to provide me with clinical anesthesia.

2. EAMA has explained to, and discussed with me the nature and purpose of the proposed anesthesia. This consists of placing a catheter into my vein and administering medicine. My vital signs will be continually monitored throughout the procedure blood pressure, electrocardiogram, oxygen saturation, respiration and pulse

3. I consent to the administration of intravenous anesthesia and the inhalation of oxygen under the direction and/or supervision of EAMA.

4. EAMA has explained and discussed with me the items that are summarized as follows:

   A. The pre-procedure, procedure and post procedure risks of anesthesia include but are not limited to inflammation of the vein, bruising and /or discoloration at the injection site, spasm of the muscles of the face, lack of coordination, drowsiness, fainting, allergic reactions, vomiting, nausea, damage to teeth of oral tissues necrosis of tissue at the injection site. brain damage. paralysis, cardiac arrest and or death.
   B. The possible of likely results of intravenous anesthesia are to keep me In a sedated or sleep like state.
   C. All feasible alternatives to the administration of intravenous anesthesia have been adequately explained by Eastside Alliance Medical Associates.
   D. I am aware that the practice of medicine is not an exact science and | acknowledges that no guarantees have been made to me concerning the results of the proposed treatment and/or anesthetic

5. I certify that I have not consumed any solid food since midnight and liquids since eight hours prior to the time of the procedure.

6. I have had sufficient time to discuss options and risks with EAMA

7. All of my questions have been answered by EAMA

8. I certify that I have read and fully understand the above consent statement which has been preceded by an explanation by my anesthesiologist and that the explanation therein referred to was made to me by EAMA.

9. I consent knowingly and voluntarily to the administration of intravenous anesthesia as outlined. At all times during the reading, explanation. and execution of this form, I possessed all of my mental faculties and was not under the influence of alcohol and/or medications.

10 EAMA will bill my insurance carrier when applicable. I hereby authorize my insurance benefits to be paid directly to David Tenembaum MD PC and acknowledge and accept full financial responsibility for my account balance EAMA will abide by all regulations of participating insurance plans.

Patient / Legal Guardian Signature: _________________________

Witness: ______________________

Anesthesia Provider: __________________________