Trinity Health Of New England | Saint Mary's Hospital

Patient Label

INFORMED CONSENT FOR ENDOSCOPY

NAME OF PATIENT	DATE OF BIRTH / /

To the patient: As a patient you have the right to be informed about your condition and any recommended surgical, medical, or therapeutic/diagnostic procedures. This information will help you decide whether or not to undergo the procedure and to understand the risks, benefits, and complications involved. This disclosure is not meant to frighten 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 voluntarily request DR(s) _____ as my physician(s), and such associated technical assistants working under his/her direction that might include resident physicians in training or medical students and other health care providers as my physician deems necessary, to treat my CONDITION which has been explained to me AS:

_____

I understand that the following surgical, medical, and/or diagnostic/therapeutic procedures are planned for me and I hereby voluntarily consent and authorize these **PROCEDURE(S):**

- ☐ **Colonoscopy with possible biopsy/polypectomy**
- ☐ **ERCP**
- ☐ **Esophagogastroduodenoscopy with possible biopsy/polypectomy**
- ☐

I understand the following are **ALTERNATIVES TO** this procedure: ☐ No operation ☐ X-rays

I understand the consequence of doing nothing is risk of cancer.

As there may be **RISKS AND HAZARDS** in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic/therapeutic procedures planned for me. I realize that common to surgical, medical, and /or diagnostic/therapeutic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, even death. I realize that the following specific risks and hazards may occur in connection with this particular operation/procedure(s).

- ☐ Perforation
- ☐ Pancreatitis
- ☐ Stroke
- ☐ Pneumonia
- ☐ Inflammation of the vein
- ☐ Pain
- ☐ Injury to another organ
- ☐ Heart attack
- ☐ Need for surgery
- ☐ Reoccurrence of disease or metastasis of cancer

Others: _____

I understand that no warranty or guarantee has been made to me as to result or cure.

I understand that these risks are not completely avoidable, and I agree to accept these risks by consenting to this procedure.

I understand that my physician may discover other or different conditions, which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I understand that during the performance of this operation or procedure, anesthesia (including moderate sedation) may be required and administered by my physician. The benefits of, risks, and alternatives associated with administration of this medication have been explained to my satisfaction.

ADVANCE DIRECTIVES:

I understand that I have the right to make an informed decision regarding my right to withhold care including to suspend, modify or maintain a Do Not Resuscitate (DNR), Do Not Intubate (DNI), Withhold CPR, or other advanced directive. I have discussed these options with my provider. My wishes are:

- ☐ I do not have any current Advanced Directive and request that all resuscitative measures be performed.
- ☐ Full Resuscitation efforts. I have an existing DNR order or other Advance Directive. I choose to suspend this existing order during surgery/and during the immediate postoperative period thereby consenting to all resuscitative measures.
- ☐ Limited Resuscitation efforts. I have an existing DNR order or Advance Directive. I choose to refuse specific resuscitation procedures during surgery and immediate postoperative measures. Specify: _____

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NAME OF PATIENT	DATE OF BIRTH / /

TRANSFUSION OF BLOOD OR BLOOD PRODUCTS ☐ NOT APPLICABLE

I have been advised by Dr. _____ , (and /or such associates selected by him/her) that I might need a blood transfusion and /or receive blood products during my hospitalization. I understand that the blood and /or blood products used by the Hospital are primarily from volunteer donors. I understand to my satisfaction the reasonable benefits and potential risks of receiving a blood transfusion: fever, allergic reactions, and transmission of diseases such as hepatitis and HIV/AIDS. While the precautions generally taken in testing and screening of the donor and his/her blood and/or blood products generally reduce the complications of transfusions, I understand that blood and blood products can never be 100% safe. I understand alternatives to receiving a blood transfusion and the common foreseeable benefits and the risks of these alternatives.

I have been advised of the consequences if I refuse a blood transfusion or a reasonable alternative to receiving a blood transfusion. I understand the options of autologous blood donations (using my own blood) and designated donor transfusions (using the blood of friends or relatives selected by me) and the Hospital's policy concerning these options. I have been informed that if I do not understand any of the information that has been provided to me regarding blood transfusion, if I have any special concerns, or I want more detailed information, I may ask more questions and get more information before signing this consent agreeing to treatment. Note: Parental consent is required for minors who are not emancipated.

REFUSAL FOR USE OF BLOOD/BLOOD PRODUCTS (▼ Signature of patient)

I DO NOT consent to the use of blood and blood products as deemed necessary _____

I consent to the disposal, by Hospital authorities, of any tissues, organs, or amputations, which may be removed during the course of the procedure.

I have been given an opportunity to ask questions, and my physician has explained possible alternative forms of treatment: the risks of transfusions; the procedures to be used, including the use of advanced technology and the hazards involved. Advanced technology includes, but is not limited to, the use of electronic, sonic, LASER, microwave, radio frequency and robotics technology.

In compliance with the Safe Medical Device Act of 1990, if an FDA designated medical device is implanted during surgery, I understand that my Social Security number and name will be released to the manufacturer.

I authorize the Hospital staff to take still photographs, motion pictures, television transmission, and/or video-taped recordings, provided my identity is not revealed by the pictures or by descriptive text accompanying them.

I understand that medical product representative(s) may be present during my surgical procedure to serve as resource personnel for products used during my procedure. This may include, for example, programming electronic devices such as a pacemaker or Automatic Implantable Cardioverter/Defibrillator, (AICD).

I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I believe that I have sufficient information to give this informed consent.

PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE) _____ DATE _____ TIME _____

Patient is unable to sign because _____

PHYSICIAN SIGNATURE _____ DATE _____ TIME _____

Name of next of kin or legal representative providing **TELEPHONE CONSENT** _____

_____

(SIGNATURE OF PHYSICIAN OBTAINING TELEPHONE CONSENT) _____ DATE _____ TIME _____

(SIGNATURE OF SECOND STAFF MEMBER HEARING VERBAL CONSENT ON THE TELEPHONE — *REQUIRED*) _____ DATE _____ TIME _____

DECLARATION OF EMERGENCY SITUATION

I believe it is essential to perform the following procedure: _____

_____ or the patient will be seriously injured or die.

SIGNATURE (PHYSICIAN, DENTIST, OR PODIATRIST) _____ DATE _____ TIME _____

SIGNATURE: _____ DATE _____ TIME _____

(*REQUIRED* — SECOND PHYSICIAN, DENTIST, OR PODIATRIST ATTESTING TO EMERGENCY SITUATION)