***TO THE PATIENT***: *You have the right to be informed about your condition and the recommended medical, or diagnostic procedure to be performed. You also have the right to be informed about the plan for sedation or anesthesia. This document will include the risks associated with both the procedure and anesthesia, as well as the benefits for each. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to proceed.* ***IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS ENTIRE CONSENT******FORM CAREFULLY*** *(or have it read to you) and that you ask questions about any information that you may not fully understand.*

**INFORMATION REGARDING YOUR PLANNED PROCEDURE:**

I consent to allow my physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and such other assisting physicians and surgical personnel as requested by my physician to perform the following procedure:

\_\_\_ **UPPER ENDOSCOPY-**possible biopsy/polypectomy/ hemostasis using cautery or clips/dilation of strictures

\_\_\_\_ **WITH SMALL BOWEL ENTEROSCOPY \_\_\_\_ WITH CAPSULE DEPLOYMENT**

\_\_\_ **COLONOSCOPY**-possible biopsy/polypectomy/ hemostasis using cautery or clips/hemorrhoid banding

\_\_\_ **FLEX SIGMOIDOSCOPY**-possible biopsy/polypectomy/hemostasis using cautery or clips/hemorrhoid banding

\_\_\_ **POUCHOSCOPY-** possible biopsy/polypectomy/ hemostasis using cautery or clips

My physician has explained to me the nature and purpose of the procedure that will be performed. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure deem necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives of the procedure. The potential risks or complications of this procedure include:

Infection Adverse reaction to medication

Aspiration Phlebitis, and/or nerve injury related to the IV catheter

Injury to organs Bleeding

Perforation Missed mass/cancer

Rare, unexpected and ***severe complications***can occur, such as cardiac or respiratory complications, stroke or death. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result. Other risks specific to this procedure may include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that there are risks with any procedure, and it is impossible for the physician to inform me of every possible complication.

My physician has reviewed the risks, benefits, and alternatives associated with performing the procedure in the Ambulatory Facility instead of a hospital.

**INFORMATION REGARDING SEDATION/ANESTHESIA:**

You, in consultation with your physician, have decided to undergo a procedure that requires anesthesia.

**The intended plan for anesthesia is:**

**MODERATE SEDATION:** Moderate sedation is a drug-induced state of consciousness during which you can still respond normally to verbal commands.

**MONITORED ANESTHESIA CARE (MAC) with IV Sedation** -Your anesthesia provider will monitor you and may provide anesthesiaby administering intravenous (injected through a catheter into your bloodstream) anesthesia drugs, such as Propofol to produce a semi-conscious state. Your level of consciousness may vary from semiconscious to unconscious depending on your response to the medications and your clinical needs.

All forms of anesthesia involve some risks. No guarantees or promises can be made that you will not suffer a side effect or complication from your anesthesia. The determination of what type of anesthesia is best for you depends on many factors including your physical condition, the type of procedure you are undergoing and the preferences of you and your physician. Rare, unexpected and *severe complications* can occur with all forms of anesthesia, including infection*; drug or allergic reactions, leading to cardiac arrest or death; nerve injury with loss of sensation or function; paralysis; stroke; bleeding; blood clots; damage to liver, kidney, lungs; heart attack; brain damage and even death.* Common side effects and specific complications of your planned anesthesia include but are not limited to those identified below.

**Risks and common side effects of anesthesia/sedation include:**

|  |  |
| --- | --- |
| * Nausea and/or vomiting | * Swelling, tenderness, bleeding and bruising at injection site |
| * Mild to moderate decreases in blood pressure and/or heart rate | * Infection, swelling or other damage to blood vessels |
| * Injuries to the mouth, lips and surrounding areas | * Soreness of the throat and hoarseness |
| * Aspiration (inhaling stomach contents into the lungs), asthma attacks, and pneumonia (lung infection and/or swelling) | * Nodules, polyps, or other damage to the vocal cords or windpipe |
| * Convulsion/seizure | * Rarely, there can be awareness under anesthesia. Dreams during anesthesia may be confused with recall of real event. |

**Teeth and dental prosthetics (such as dental implants, veneers, caps, crowns, and bridges) may become loose, broken, or dislodged, regardless of the care provided. By signing this consent, you are acknowledging that neither your anesthesia providers, physician, the facility, nor the company employing or engaging the anesthesia providers will be responsible for any dental damage or repair costs.**

I understand that the administration of anesthesia will be supplied under the direction of my physician. I understand that anesthesia services are being provided by **WCS Sedation** LLC. Your anesthesia provider will monitor you and may provide anesthesiaby administering intravenous (injected through a catheter into your bloodstream) anesthesia drugs, such as Propofol to produce a semi-conscious (deep sedation) state. Your level of consciousness may vary from semiconscious to unconscious depending on your response to the medications and your clinical needs.

**ADDITIONAL INFORMATION**

Independent Practitioners: I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist and the like are independent practitioners exercising their independent clinical judgment. They are not employees or representatives (agents) of the center.

In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the procedure to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer’s representative, for technical assistance, or a student, for continuing education, to be in attendance during my surgery or procedure if the situation arises.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the procedure.

**I do hereby consent** to the performance of the planned procedure and anesthesia; or changes to the plan as may be considered necessary or advisable. By signing below, I HEREBY CERTIFY that I have read this consent form (or had it read to me) and that my physician has fully explained it to me. I have reviewed and understand the risks, benefits and alternatives of the planned procedure and anesthesia. I have had the opportunity to ask questions, all of which were answered to my satisfaction.

The undersigned certifies that he/she has read the foregoing and the patient, the patient’s legal guardian, or the patient’s authorized representative accepts its terms.I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction. I attest that I am 18 years of age or older, my judgment is not impaired by any legal or illegal substance, and I am signing this consent of my own free will and have not been forced by any person to consent to this procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Patient / Patient’s Representative Signature / Relationship Witness’ Signature Date Time

**Physician Statement**

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of both the procedure being performed and the administration of anesthesia related to that procedure, as outlined in all three pages of this Procedure and Anesthesia Consent form. I have allowed the patient/responsible adult to ask questions about both the procedure being performed and the administration of anesthesia related to that procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date Time