Michael Ammirati, MD
Samuel Schwarz, MD
Informed Consent for Endoscopic Procedures

Date:_____Patient:_____

1. I authorize the performance of the following procedure(s):
□ Colonoscopy □ Esophagogastroduodenoscopy (EGD) □ Biopsy □ Polypectomy
□ Dilation □ Other:_____on myself by
_____, MD.

2. I am aware that the alternatives to a Colonoscopy/ EGD include but are not limited to: diagnostic testing, barium X-ray studies, and CT colonography. These alternatives are not recommended for me at this time, but may be recommended subsequently for diagnosis or treatment of GI tract conditions
3. The risks of endoscopic procedures include: pain, bleeding, infection, perforation of the bowel (the creation of a hole in the wall of the bowel) and adverse reactions to the medications used during the procedure.
4. I am aware that in the event of complications, it may be necessary to transfer me via ambulance to the emergency room of a hospital for treatment and/or surgery, to sustain my health.
5. I consent to the performance of any procedure in addition to those now contemplated, which the physician may consider necessary in the course of the procedure.
6. I acknowledge that no guarantee or assurances have been given by anyone as to the results that may be obtained.
7. I am aware of my responsibilities as a patient: I am responsible for full disclosure of my medical history, and for reporting symptoms that may occur during or after the procedure. I am expected to report to the physician and all staff any medications (including nonprescription drugs, medicinal or dietary supplements) that I have taken recently including the day of the procedure.
8. If staff or employees should sustain a blood-borne exposure from my blood or body fluids while I am a patient at this facility, I consent to having blood drawn for HIV and hepatitis studies. The results will be kept confidential.
9. I am aware that if I have an advance directive it is temporarily suspended while I am a patient at this facility.
10. I consent to the examination and disposal by the pathologist of any tissue that may be removed.

By signing this form, I acknowledge that the risks and alternatives of the procedure have been explained to me by the physician, that I have read or had this form read and / or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that my questions have been answered satisfactorily.

Patient Signature:_____

Physician Signature:_____

Witness (to signatures only):_____