

Patient Sticker

# INFORMED CONSENT FOR OPERATION OR OTHER PROCEDURE

1. I authorize Dr.(s) **Salim/Lee** and/or such assistants as may be selected by him/her or them to attempt to remedy the following condition(s) and/or symptom(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. The conditions listed in paragraph #1 have been explained to me and I understand that the operation(s) or procedure(s) designed to remedy the condition(s) is: **Colonoscopy with / possible biopsy, possible hemorrhoidal banding EGD with / possible biopsy / possible dilation**

Consent Update

Patient Consent validation, if signatures/date is greater than 30 days prior to the procedure date. Initial below:

Practitioner\_\_\_\_\_\_\_\_\_\_\_ Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_

Time\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I have been informed of the nature and proposed operation or procedure; the risks and possible consequences involved, **Bleeding, infection, perforation of the colon/ esophagus/ stomach**

The alternative methods of treatment: **None**

And the probable result if the operation or procedure is not undertaken: **Unknowns, risk of cancer**

1. My practitioner and I have discussed the potential for blood or blood product transfusion related to this procedure. I understand the risks associated with the use of blood and/or blood products include reactions, transmission of disease, and unforeseeable risks including death. I consent to the use of blood products during the operation or procedure and subsequent hospitalization if indicated.
2. **I do not consent to the use of blood or blood products. I understand that I must notify my physician immediately and will be asked to sign the Refusal to Permit Blood Transfusion form. \_\_\_\_\_\_\_\_\_ (*Initial*)**
3. No guarantees or assurances have been made to me concerning the results of the proposed operation or procedure.
4. I recognize that, during the course of the operation, additional or different procedures other than those described above, may be necessary. I authorize such procedures as are, in my doctor’s professional judgment, desirable to my health, including attempts to remedy any conditions not known at this time, which are discovered during the operation or procedure.
5. I consent to the administration of anesthesia and to the use of such anesthetics as may be advisable, by my doctor, his/her associates or assistants, or under the direction of the nurse anesthetist selected by my doctor.
6. I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my surgeon(s).
7. I consent to the photographing of the surgery or procedure(s) to be performed, including appropriate portions of my body for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.
8. I authorize this hospital to preserve for scientific or teaching purposes, or to otherwise dispose of the tissue or organs resulting from the procedures authorized above.
9. I understand that, unless otherwise instructed, I am required to have a responsible adult accompany me after my surgery/procedure(s) and that I will be released to that person’s custody, and must rely upon him/her for my return home and supervision, as instructed.
10. I certify I have read, and fully understand the above consent to operation or procedure and that it is my intention to have the above operation or procedure carried out as stated. **NOTE: IF YOU HAVE ANY QUESTIONS AS TO THE PROPOSED SURGERY OR PROCEDURE, OR THE RISKS, HAZARDS, OR CONSEQUENCES INVOLVED THEREIN, ASK YOUR PROVIDER NOW – BEFORE YOU SIGN THIS CONSENT FORM.**

Patient or person authorized to sign for patient Relationship Date Time

Witness to Signature Date Time

PROVIDER DECLARATION: I have fully explained to the patient all matters included in this document and have answered all the patient questions, and, to the best of my knowledge and belief, the patient has been adequately informed and CONSENTED to undergo the proposed surgery procedure.

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Provider’s Signature Date Time