The Endoscopy Center of Fairfield

Gastroenterology Associates of Fairfield County, P.C.

(203) 292-9000
425 Post Road
Fairfield, CT 06824

(203)333-3328
2660 Main St
Bridgeport, Connecticut 06606

Patient Name:
Referring MD:
DOB: Age:
Chart Number: Date:
Gender:

Consent for Endoscopic Procedures, Other Special Procedures, and Sedation or Analgesia

Date_____

I hereby authorize Dr_____ to perform the following procedure: _____

_____

The general nature of the anticipated procedure, the medically accepted alternative procedures and the potential risks inherent in the proposed treatment have been explained to me, I understand such risks and I consent to the procedure. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

I voluntarily consent to the proposed procedure at this facility. It has fully explained to me that during the course of the procedure, it is possible that unforeseen conditions including but not limited to bleeding, infection, drug reaction, perforation, post-polypectomy burn syndrome and missed lesions could occur and may necessitate additional or different procedures than those described to me, including surgery. I authorize and request that my physicians, his/her assistants or his/her designees, perform such additional procedures as are deemed necessary. I consent to be transferred to a hospital in the event that my condition warrants such a transfer.

I consent to the administration of sedation or analgesia via topical, local injection or intravenous routes as deemed advisable and administered by my physician. I understand that sedation or analgesia bears some risk of injury, allergic reaction or rarely death even when administered by the most competent physician.

For the purpose of advancing medical education, I consent to the admittance of approved observers to the procedure room. I consent to the photographic documentation of the findings for medical purposes, provided the pictures or descriptive text accompanying them does not reveal my identity.

I consent to pathologic evaluation of any tissue, which is removed in accordance with the medical staff rules and regulations of this Endoscopy Unit.

_____

Patient/Guardian **Date** **Time**

_____

Witness to patient or Guardian Signature

I have discussed with the patient the risks, benefits and alternatives to the proposed procedure(s).

_____

Physician Signature