

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is _____
2. The nature of the procedure is checked off and initialed by me as indicated on side one.
3. As a result of this procedure being performed, there may be risks or potential complications including: abnormal heart rhythm, trouble breathing, allergic reaction to the sedative medications, bleeding, the possibility of missing a lesion, perforation of the gastrointestinal tract, infection, thrombosed vein or IV infiltration, or death.
4. In addition, with liver biopsies there are additional risks and potential complications including: the risk of perforation of another organ (i.e. gallbladder, lung, bowel, or kidney), bleeding from the biopsy site, pain resulting from the biopsy, or the possibility of not obtaining a specimen.

I certify that I understand the information regarding gastrointestinal endoscopy with or with out intravenous sedation. During this procedure, if I receive conscious sedation, (the risks of which are the same as above in paragraph 3), **I agree not to drive myself home after the procedure and will have a responsible adult drive me or accompany me home after my discharge from the endoscopy center.**

I understand that my physician, medical personnel and other assistants have relied on statements about my medical history and other information in determining the need for this procedure and course of treatment.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures, which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described therein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I consent to diagnosis studies, tests, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described therein.

I also consent that any tissues or specimens removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician or pathology lab.

I further consent to the taking and reproduction of any photographs in the course of this procedure for professional purposes.

BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.

I hereby voluntarily request and consent to the performance of the the procedure described or referred to herein by Dr. _____ and any other physicians or other medical personnel who may be involved in the course of my treatment.

Signed: _____ Date and Time: _____

Witness: _____ Physician Signature: _____