CONSENT FOR ENDOSCOPY PROCEDURE(S)

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to as gastrointestinal Endoscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, the lining may be brushed and washed with a solution, which can be sent for special study for abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). Occasionally during the examination, a narrowed portion of intestine (stricture) will be stretched to a more normal size (dilation).

The principal risks of these procedures are:

· Injury to the digestive tract by the instrument, which may result in perforation of the digestive tract with leakage of intestinal juices into body cavities; if this occurs, surgery to close the leak and/or drain the region is usually necessary.

· Bleeding, which, if it occurs, is usually a complication of biopsy, polypectomy, dilation, banding, or infrared coagulation. Management of this complication may consist only in careful observation or may require transfusion or possibly a surgical operation for control.

· Aspiration- While you are asleep it is possible to have saliva or other fluid flow into the trachea (windpipe). If this occurs, it may result in coughing and in some cases pneumonia.

· Other risks include drug reactions and complications from other associated diseases, which you may have such as a stroke or heart attack. You should inform your physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for gastrointestinal Endoscopy.

Although gastrointestinal Endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result; including missing significant growths or even cancer. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray, and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

A brief description of each endoscopic procedure follows:

· EGD (GASTROSCOPY) Examination of the esophagus from the throat to the entrance of the stomach, the stomach pouch, and the small intestine just beyond the stomach. Biopsy, cytology, dilation and/or use of equipment to apply heat or electric current to a bleeding site to stop bleeding may be necessary.

· DILATION The passing of progressively larger rubber or balloon bougies, through the mouth down the esophagus stretching any narrow portions or strictures to a more normal size.

· SCLEROTHERAPY Injection of medication into a bleeding site to stop bleeding.

· FLEXIBLE SIGMOIDOSCOPY Examination of the anus, rectum, and lower part of the colon (large intestine). Biopsy, cytology, dilation, polypectomy, and/or use of equipment to apply heat or electric current to stop bleeding may be necessary.

· COLONOSCOPY Examination of all or part of the large intestine requiring careful preparation with diet, enemas and/or medications. Biopsy, cytology, dilation, polypectomy and/or use of equipment to apply heat or electric current to stop bleeding may be necessary.
INFRARED COAGULATION OF HEMORRHOIDS Treatment of hemorrhoids with light energy causing tissue to shrink and recede.

PARACENTESIS Insertion of a needle or catheter into the abdomen to withdraw fluid.

PEG/PEJ (Percutaneous Endoscopic Gastrostomy/Jejunostomy) Used in conjunction with gastroscopy; insertion of a tube into the stomach/small intestine through a small incision in the abdomen for feeding or medication.

BANDING Application of elastics to enlarged rectal and/or esophageal veins.

BRAVO ESOPHAGEAL PH MONITORING SYSTEM. Placement of capsule to the lining of the esophagus with endoscope. The probe remains in the esophagus transmitting its information to a portable digital recorder worn around the waist and after a few days it should fall off and pass uneventfully through your gastrointestinal track.

*** Additional risks associated with banding and infrared coagulation of hemorrhoids include the following: Difficulty urination, scarring of anal canal which can cause narrowing and difficulty passing stool, recurrent hemorrhoids, remaining hemorrhoids may become inflamed, or infection which on rare occasions can be very severe***

I consent to the taking and publication of any photographs in the course of this procedure for the purpose of treatment and medical education. I certify that I understand the information regarding gastrointestinal Endoscopy and that I have been fully informed of the risks and possible complications thereof. I hereby authorize and permit (DOCTOR) and whomever he may designate to perform upon me the following procedure (PROCEDURE). If any unforeseen condition arises during this procedure calling for his/her judgment for additional procedures, operations, or medications (including anesthesia and blood transfusion), I further request and authorize him to do whatever he deems advisable, (including transfer to an acute care facility). I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of this procedure.

I have read the above paragraphs and all the blanks are filled in. I understand the procedure(s) to be performed on me and the risk(s) associated to the performance of the procedure(s).

ENDOSCOPY DISCHARGE INSTRUCTIONS

You will receive sedation for your procedure. For your safety: **DO NOT**
operate any machinery or drink Alcohol for 24 hours. **DO NOT** make important decisions or sign legal papers for 24 hours. **DO NOT** drive a vehicle for 24 hours. If after 24 hours you are fully awake, you may resume the above activities.

The above instructions have been explained to me prior to receiving medication. I understand them. I know that the physician will explain his findings after my test, and I will receive a copy of this form.
ANESTHESIA CONSENT
Outpatient Anesthesia Specialist LLC
7152 Coca Sabal Lane
Fort Myers, FL 33908

I hereby authorize and direct Outpatient Anesthesia Specialist LLC. and individual anesthesia provider to provide anesthesia services as part of my upcoming surgery or procedure.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the surgery or procedure. I understand Outpatient Anesthesia Specialist LLC. will be administering intravenous Propofol or other medications deemed necessary by anesthesia personnel or physician to render me insensible to pain and the recollection of this procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common risks and complications associated with it. These may include but are not limited to: swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to the blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; aspiration; pneumonitis; and prolonged recovery from anesthesia. There is also a real potential for serious harm, including difficulty breathing, permanent organ damage, cardiac arrest and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I have been given the opportunity to ask questions about the anesthesia. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any surgery or procedure, and it is impossible for the physician to inform me of every possible complication. I believe that I have sufficient information to give this informed consent.

In the event my physician, anesthesia provider, or staff is exposed to my blood, body 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.

Lifetime Authorization for Medicare/Insurance Certification for Payment

I certify that the information given for payment under Title XVII of the SSA is correct. I authorize Outpatient Anesthesia Specialist LLC. and their agents and contractor’s to use this signature as a release to the Social Security Administration or it’s intermediaries or carriers, or to the billing agent of anesthesia claims or suppliers, any information needed for this or a Medicare claim. I request that the benefits be made on my behalf. I permit a copy of this be used in place of the original. I may revoke this authorization by notifying Outpatient Anesthesia Specialist LLC in writing. I request that this authorization apply to all insurance.

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Outpatient Anesthesia Specialist LLC and their agents and contractors for any services furnished to me. I authorize any holder of medical information about me and or information needed to determine these benefits payable for related services to release it to my Medigap insurer.

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.