Endoscopy Center of Connecticut, LLC

Hamden / Guilford

Consent for Endoscopic and Other Special Procedures

Patient:_____ Date:_____

I hereby authorize Dr. _____to perform the following procedure(s):
□ upper endoscopy □ colonoscopy □ sigmoidoscopy □ pouchoscopy
□ biopsy □ polypectomy □ dilation □ Bravo test □ Pillcam placement □ other_____

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 been 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 reactions, 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 physician, 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.

For the purpose of advancing medical education or equipment assistance 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 the pathologic evaluation of any tissue, which is removed in accordance with the medical staff rules and regulations of the Endoscopy Center of Connecticut.

I consent to care at the Endoscopy Center of Connecticut with the knowledge and understanding that while under the care of the Endoscopy Center of Connecticut, due to reasons of conscience, the center will choose to use life saving measures in the event of a medical emergency requiring resuscitation, without limitations, and transferred to the hospital, at which time any Advance Directives will be made known to the receiving physician.

Executed Advance Directive □ Yes □ No If yes, is a copy available?_____
If no, does patient want information on Advance Directives? □ Yes □ No **(Initials)** _____

I have received a copy of the Patient Bill of Rights and I consent to care at the Endoscopy Center of Connecticut with the knowledge that this facility is owned exclusively by the physicians of PACT Gastroenterology and HHC Surgical Center Holdings, LLC. I have voluntarily chosen this facility over similar facilities in the area. **(Initials)** _____

Patient Signature_____**Date**_____

If the patient is a minor or unable to sign, complete the following:

Patient is a minor_____years of age or unable to sign because _____

Closest relative or Legal Guardian Signature_____

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

Physician Signature_____