McLaren
GREATER LANSING

CONSENT TO ENDOSCOPY PROCEDURES

My name is (patient name) _____

My Doctor is _____

The procedure(s) which is planned is (are)

- ☐ Esophagogastroduodenoscopy, possible biopsy, possible dilation, possible coagulation, injection or sclerotherapy, possible band ligation
- ☐ Possible Percutaneous Endoscopic Gastrostomy Feeding Tube Placement
- ☐ Colonoscopy, possible biopsy, possible polypectomy, possible coagulation, injection or sclerotherapy
- ☐ Endoscopic retrograde Cholangiopancreatography, possible sphincterotomy, possible stent placement, possible stone extraction
- ☐ Other: _____

1. I request that the above listed procedure(s) be performed at McLaren Greater Lansing.
2. My doctor may have other doctors assist or do part of the procedure(s). I also give my consent to the nurses and technical people at McLaren Greater Lansing to do the things they usually do during such procedure(s).
3. It was explained that during my procedure another physician, advanced practice provider or health professional student may be performing surgical tasks during the procedure, sensitive/intimate exams, or invasive procedures for educational or training purposes.
4. The doctors may find something they did not expect. If this happens, the doctors may use their judgment and change the procedure(s) as necessary.
5. I know medical science is not perfect and many things are not predictable. I know I could be in McLaren Greater Lansing, sick or disabled, much longer than anyone expects. Nobody has given a promise or guarantee or what the results of the procedure will be. I have also been informed that in the performance of any surgical or invasive medical procedure there are risks such as severe loss of blood, missed polyps or lesions, perforation requiring surgery, pancreatitis, severe medication reactions, pneumonia, infection, cardiac or respiratory arrest and death.
6. I understand that certain complications may result from the use of any sedation (moderate or anesthesia), including respiratory problems, drug reactions, drug allergies, paralysis, brain damage or even death. I have been given an opportunity to ask questions about my condition, alternative forms of sedation and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
7. I understand the reasons for the surgery/procedure, advantages, possible complications of the procedure, and possible alternative modes of treatment including their risks and benefits and prognosis if the treatment is not rendered. I understand the risks associated with the procedure. The benefits and side effects of the procedure have been explained to me as well as the estimated period of hospitalization and what to expect for a recovery period. The effect on my future health has been explained to me. I am aware that in the practice of medicine, other unexpected risks of complications not discussed may occur.
8. I have been informed and understand that anesthetic may be used in connection with the described operation/procedure, including the risks, advantages, possible complications and consent to the administration of such anesthetics as may be considered necessary or advisable.
9. I understand that I may be given medication during the procedure and I know it is up to me to tell the doctors about allergies I have, drugs or medicines I have taken, when I have eaten or taken alcohol, any drugs or medicines I should not have and any other health problems I have. I understand it is important to my health and safety that I follow the doctors' instructions before and after the procedure.
10. I know I could lose blood. If this happens, I may need blood or products made from blood. I wish to receive blood and blood products if the doctors feel it is necessary. I understand that despite careful testing and screening of blood and blood products by collecting agencies, I may still be subject to ill effects of receiving a blood transfusion and/or blood products, including but not limited to fever and allergic reactions, hemolytic reactions, transmission of disease such as hepatitis, AIDS (HIV) and cytomegalovirus (CMV), and fluid overload.

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11. I know that specimens, implants and tissues may be taken from my body during the procedure. I give permission for these to be used for teaching purposes, scientific reasons or disposed of in accordance with hospital procedures.
12. I also consent to the photographing or videotaping of any procedures or treatment to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is **not** revealed outside of the hospital by the pictures or written description accompanying them. I further consent to the presence of the technicians who are to participate in the photographing or videotaping. I waive all rights, claims, and interest in all audiovisual recordings and all rights to payment and royalties in connection with their use and/or publication.
13. I understand McLaren Greater Lansing participates in educational programs of universities and other health care institutions. I also understand that my attending physician may be assisted not only by hospital employees, but persons in training from other institutions who have been given permission to do so by McLaren Greater Lansing. I also understand that observers may be present for the purpose of education who have been given permission to observe by McLaren Greater Lansing..
14. My doctor has answered all of my questions to my satisfaction. I understand that if I think of any more questions, I should ask them before the procedure and my doctor will answer them.

I have read (or have had read to me) the above "Consent to Endoscopy Procedures." I know what it means. I request and consent to having the procedure listed above performed. I understand if I change my mind, I must tell the physician in charge of the procedure immediately and ask for this form back and place a big "X" over my signature and write my initials next to the "X."

_____ _____ Date _____

Signature of Witness Signature of Patient

Time _____

ALTERNATE CONSENT AND SIGNATURE

If the patient is too young to sign (a minor) or is not able to understand what the form means because of illness or mental condition, this section must be completed.

Name of patient: _____ Patient's age: _____

Reason patient unable to sign for self: _____

I hereby request and consent to the procedure on behalf of the patient because the patient is unable to sign for him/herself.

_____ _____ Date _____

Witness to Signature Signature of Parent or Other Person

Time _____

_____

My Relationship to Patient

PROVIDER ACKNOWLEDGMENT

I, or any physician associate, have discussed the nature, risks, benefits and alternatives of the procedure with the patient, patient's relative or other person (identified above).

_____ _____ Time _____

Signature of Physician Date of Explanation