[redacted]

I [redacted] am consenting for the following procedure(s):
(printed name of patient)

1. portal vein recanalization (possible angioplasty, stenting, thrombolysis)
2. possible tapping of shunt
(name of procedure and description in lay language)

which will be performed by the Interventional Radiology team including Brian Funaki, MD, Jonathan Lorenz, MD, Thuong Van Ha, MD, Rakesh Navuluri, MD, Jeff Leef, MD, Steven Zangan, MD. The primary attending will be assigned per rotation and availability just prior to the procedure and may be assisted by whomever he/she may designate as necessary to perform the procedure.

If any unforeseen condition arises in the course of the procedure calling in the physician's judgment for procedures in addition to or different from those now planned, I further request and authorize the physician to do whatever the physician deems medically advisable.

I consent to the administration of moderate sedation, deep sedation or general anesthesia and to the use of such medications as my physicians may deem advisable. The type and purpose of the sedatives, pain medications, and/or anesthetics, possible alternative methods of sedation or anesthesia, and the possibility of complications have been fully explained to me.

I received information about my condition and the purpose of my treatment. I received information and discussed with my healthcare team the specific procedures to be performed, including the anticipated benefits and the material risks and possible side effects of the procedures. Some of the risks my physician discussed with me include:

pain
infection
bleeding, vessel injury

Additional risks and complications may occur. I understand that this document is not intended to include a list of all known risks and complications associated with the procedure.

I received information and discussed with my healthcare team the possible alternative methods of treatment, the risks related to not receiving the proposed treatment, and the likelihood that the proposed treatment will be successful. No guarantee or assurance has been made to me that this procedure will improve my condition. I also received information and discussed with my healthcare team the expected post procedural course and discomforts of the procedure.

I understand that because The University of Chicago Medicine (UCM) is a teaching institution, other physicians, including fellows and residents, in addition to APNs, PAs and medical students acting under the supervision and direction of my primary physician may perform important tasks related to the procedure. I also understand that qualified medical practitioners who are not physicians may perform important parts of the procedure or the administration of anesthesia that are within their scope of practice and for which they have been granted privileges by UCM.

CS

JAN 3 0 2018

[redacted]

CONSENT FOR IR DIAGNOSTIC OR THERAPEUTIC PROCEDURES

CONSENT FOR BLOOD TRANSFUSION: I have been told that I may need a transfusion of blood or blood products and have been told what the benefits to me might be. If appropriate, I have received information about transfusion alternatives, including autologous and directed donations.

I have been told how a blood transfusion is given and the possible risks and consequences of the transfusion, including bruising, an allergic reaction, fever and hives, and being exposed through transfusion to infectious disease, such as hepatitis and HIV. The estimated risk of getting HIV from a transfusion is approximately 1 in 2 million per unit of blood transfused. The estimated risk of getting hepatitis is approximately 1 in 1.6 million for Hepatitis C virus and 1 in 150,000 for Hepatitis B virus per unit of blood transfused.

I understand that every possible precaution is taken by the Blood Bank in choosing donors and in matching blood for transfusion. I have had a chance to ask my physician and/or nurse other questions about the transfusion process and its risks and consequences and they have answered them. I understand this consent for blood products is valid for my entire hospitalization or until I withdraw my consent for blood transfusions.

_____ I consent to the use of blood and blood products
Patient Initial

_____ I **DO NOT** consent to the use of blood and blood products
Patient Initial

I authorize films, videos, photographs or other images or recordings of this procedure to be taken for medical, scientific, or educational purposes provided the pictures do not reveal my identity, and I am not identified by name.

I consent to the study and disposal by UCM of any tissues or body parts that may be removed.

For the purpose of advancing medical education, I also consent to and authorize appropriate observers, including students in the health care professions, to be present in the procedure room.

I acknowledge that my physician and his/her healthcare team have provided me with the information described above regarding my surgery/procedure. I have had an opportunity to discuss the procedure and anesthesia with the physician(s) involved, I have been given an opportunity to ask questions and my questions have been answered.

I acknowledge that I have reviewed and fully understand the entire contents of this form.

Patient/Representative Signature: [redacted]

Patient/Representative Printed Name: [redacted]

Date: 1/16/18 **Time:** 240PM

As the Physician or LIP obtaining this consent, I have explained the anticipated benefits, relevant risks and alternatives with this patient and/or representative.

Physician Signature: [redacted]

Physician Printed Nam [redacted] **Pager #:** 7302

Witness for Telephone Consent Only: _____ **Pager #:** _____

Date Signed: 1/16/18 **Time:** 2:40pm

THE UNIVERSITY OF CHICAGO MEDICINE

[redacted]

Informed Consent Form

Organ Transplant Surgery

I acknowledge that [redacted] (name of physician) and his/her healthcare team have provided me with the information listed below regarding my **transplant** surgery. I have had an opportunity to discuss the procedure and anesthesia with the physician(s) involved, I have been given an opportunity to ask questions and my questions have been answered.

I acknowledge that [redacted] (name of attending surgeon) is the responsible practitioner performing the Liver transplant- (name of procedure) surgery.

I also understand that because UCM is a teaching institution, Fellows, Residents, and other healthcare providers, acting under the supervision and direction of my primary surgeon/practitioner may perform important tasks related to the surgery.

If any unforeseen condition arises in the course of the procedure calling in the physician's judgment for procedures in addition to or different from those now contemplated, I further request and authorize the physician to do whatever the physician deems medically advisable.

I consent to the administration of anesthesia to be applied under the direction of the UCM Department of Anesthesiology and to the use of such anesthetic as they may deem advisable. The nature and purpose of the anesthesia, possible alternative methods of anesthesia and the possibility of complications have been fully explained to me.

I received information about my diagnosis, prognosis, and treatment plan, including an explanation of the risks, complications, benefits, and any alternative methods of treatment.

I received information and discussed with my healthcare team the transplant surgery, the specific procedures to be performed during the surgery, and the potential medical and psychosocial risks involved in transplantation. I understand that specific risks to this surgery include, but are not limited to: Death, transplanted organ poor function, transplanted organ non-function, need for re-transplantation, and transmission of disease from the donor. Additional risks in this case include:

Pain, bleeding, infection, thrombosis, anesthesia risk, need for additional procedures, death.

CS July 2017

JAN 3 0 2018

I received information and discussed with my healthcare team the possible alternative methods of treatment, the probability that the proposed treatment will be successful, and the probability of recovery if no treatment is received. No guarantee or assurance has been made to me as to the results that may be expected. Further, the UCM transplant outcomes have been disclosed.

I received information and discussed with my healthcare team the expected post-surgical course and discomforts of the transplant surgery.

I understand that examination, testing, disposal, photographs, or preservation of any tissue, parts or organs, including the use for research or teaching purposes may occur during the transplant surgery, in such manner that may be determined by UCM, its employees or agents.

I authorize films, photographs, videos, or other recordings of this surgery to be taken for the purpose of medical research or education provided the pictures do not reveal my identity and I am not identified by name.

If I have a DNR order, Living Will, or Advance Directive that express my desire to avoid heroic measures such as cardiopulmonary resuscitation, I understand and consent to the suspension of such orders for the duration of the surgical procedure and recovery period, and request that my wishes be reinstated following the recovery period.

Consent for Blood Transfusion: I have been told that I may need a transfusion of blood or blood products and have been told what the benefits to me might be. I have received information about transfusion alternatives, including autologous and directed donations.

I have been told how a blood transfusion is given and the possible risks and consequences of the transfusion, including bruising, an allergic reaction, fever and hives, and being exposed through transfusion to infectious disease such as hepatitis and HIV. The estimated risk of getting HIV from a transfusion is approximately 1 in 2 million per unit of blood transfused. The estimated risk of getting hepatitis is approximately 1 in 1.6 million for Hepatitis C virus and 1 in 150,000 for Hepatitis B virus per unit of blood transfused.

I am told that every possible precaution is taken by the Blood Bank in choosing donors and in matching blood for transfusion. I have had a chance to ask my doctor and/or nurse other questions about the transfusion process and its risks and consequences and they have answered them. I understand this consent for blood products is valid for my entire hospitalization or until I withdraw my consent for blood transfusions.

☑ I consent to the use of blood products ☐ **I DO NOT** consent to the use of blood products

[redacted]

☑ Check here if: The donor organs have been procured from a donor flagged as Increased Risk by the Organ Procurement Organization (OPO).

I understand that the Organ Donor risk factors that could affect the success of my transplant surgery include, but are not limited to, donor history, condition or age of organs used, patient's potential risk of having contracted the HIV virus and other infectious diseases. I also understand that the donors and recipients will be screened and/or tested for infectious agents and diseases by the Organ Procurement Organization using currently available tests and screening tools. I understand that it is possible that the screening tools could fail to identify a donor's risk factors and/or that these tests could be negative despite the presence of an infectious virus, including HIV, hepatitis, or other transmissible disease. I understand that there is no method of completely ensuring that infectious diseases will not be transmitted by organ transplant and I accept that risk. I understand the donor has been identified as High Risk by the OPO and I consent to the use of the organ(s) in the transplant surgery.

[redacted] **I accept the organ(s) procured from the donor flagged as Increased Risk by the OPO**

(Pt Initials)

[redacted]

CS

JAN 3 0 2018

Organ Transplant Outcomes at the University of Chicago Medicine: The following information shows the success rates of organ transplant at our facility one year after transplant surgery. This is measured by patient survival (if the recipient is alive) and graft survival (if the organ is working one year later). "Observed" rates are the specific rates at our center, and "Expected" rates are what rates our center should have, based on the characteristics of our patients. The "national" rates are the average success rates of all transplant centers in the country. **Currently, the University of Chicago Medicine meets all requirements for transplant centers.** This information is available online at www.srtr.org

This information is for patients transplanted between 01/01/2014 and 06/30/2016. This is the most recent data provided, released in **July of 2017**.

Organ	Patient Survival Observed	Patient Survival Expected	National Patient Survival	Graft Survival Observed	Graft Survival Expected	National Graft Survival
Kidney	96%	97%	97%	96%	95%	95%
Pancreas	100%	97%	98%	*	*	*
Combined Kidney-Pancreas	100%	97%	98%	100% kidney*	96% kidney*	96% kidney*
Adult Liver	94%	92%	92%	87%	89%	90%
Pediatric Liver	100%	95%	96%	82%	87%	91%
Lung	83%	89%	88%	84%	88%	87%
Heart	89%	92%	91%	89%	92%	91%
Pediatric Heart	_	_	_	100%	95%	92%
Pediatric Kidney	100%	**	100%	100%	**	97%

**Rates are not calculated for pancreas graft survival, since pancreas graft failure has not yet been defined.*
_ Center did not perform any transplants relevant to pediatric Heart transplant 1-year patient survival during the period of 01/01/2014-6/30/2016.
***Centers expected Kidney survival rates are not calculated for pediatric recepients.*

I hereby authorize UCMC to perform the transplant surgery described above and I acknowledge that I have reviewed and understand this form.

Patient/Representative Signature: [redacted]

Patient/Representative Printed Name: [redacted]

Date: 1/12/18 **Time:** 631 pm

Physician/APN/PA Signature: [redacted]

Physician/APN/PA Printed Name: [redacted] Pager#: 4252. MD DS

Date Signed: 1/12/18

Time: 6:01

[redacted]

CS

JAN 3 0 2018

If organ donor is in high-risk category, provide the following page of high-risk behavior information to the patient.

U.S. Public Health Service (PHS) Guidelines for Increased Risk Behavior:

The information below outlines the PHS definition of increased risk for organ donors. **For complete information, see the U. S. Public Health Service (PHS) Guidelines for Reducing Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus Transm ssion through Organ Transplantation published in Public Health reports, July-August 2013, Volume 128.** *Donors who meet one or more of the following 11 criteria should be identified as being at increased risk for recent HIV, HBV, and HCV infection. Each factor listed reflects increased risk of all three pathogens as an aggregate, as there is overlap of associated risk, even though each actor does not convey risk from all pathogens equally. The first six risk factors address sexual contact; the definition of "had sex" refers to any method of sexual contact, including inal ana and oral contact:*

- *People who have had sex with a person known or suspected to have HIV, HBV, or HCV infection in the preceding 12 months*
- *Men who have had sex with men (MSM) in the preceding 12 months*
- *Women who have had sex with a man with a history of MSM behavior in the preceding 12 months*
- *People who have had sex in exchange for money or drugs in the preceding 12 months*
- *People who have had sex with a person who had sex in exchange for money or drugs in the preceding 12 months*
- *People who have had sex with a person who injected drugs by intravenous, intramuscular, or subcutaneous route for nonmedical reasons in the preceding 12 months*
- *A child who is #18 months of age and born to a mother known to be infected with, or at increased risk for, HIV, HBV, or HCV infection*
- *A child who has been breastfed within the preceding 12 months and the mother is known to be infected with, or at increased risk for HIV infection.*
- *People who have injected drugs by intravenous intramuscular, or subcutaneous route for nonmedical reasons in the preceding 12 months*
- *People who have been in lockup, jail, prison, or a juvenile correctional facility for more than 72 consecutive hours in the preceding 12 months*
- *People who have been newly diagnosed with, or have been treated for, syphilis, gonorrhea, Chlamydia, or genital ulcers in the preceding 12 months.*

Donors who meet the following criterion should be identified as being at increased risk for recent H CV infection only:

- *People who have been on hemodialysis in the preceding 12 months*

[redacted]

CS

July 2017

JAN 3 0 2018

AT THE FOREFRONT
UChicago Medicine

[redacted]

CONSENT TO MEDICAL/SURGICAL PROCEDURES

I authorize Dr. McConville and whomever he/she may designate as
(Name of attending physician)

necessary to perform upon [redacted] the following procedure(s):
(Name of Patient)

① Paracentesis ② Arterial Line Insertion
(Name of procedure and description in lay language)

If any unforeseen condition arises in the course of the procedure calling in the physician's judgment for procedures in addition to or different from those now planned, I further request and authorize the physician to do whatever the physician deems medically advisable.

I consent to the administration of moderate sedation, deep sedation or general anesthesia and to the use of such medications as my physicians may deem advisable. The type and purpose of the sedatives, pain medications, and/or anesthetics, possible alternative methods of sedation or anesthesia, and the possibility of complications, including but not limited to the principle risks of decreased rate of breathing, low oxygen level, low blood pressure, changes in my heart rate and its rhythm, prolonged drowsiness, nausea and vomiting, breathing problems, getting stomach acid into my lungs and irritation to the vein where medication is given, have been fully explained to me.

I received information about my condition and the purpose of my treatment. I received information and discussed with my healthcare team the specific procedures to be performed, including the anticipated benefits and the material risks and possible side effects of the procedures. Some of the risks my physician discussed with me include: ① Bleeding ② Vascular Damage
Infection ③ Nerve Damage
Bowel Perforation

Additional risks and complications may occur. I understand that this document is not intended to include a list of all known risks and complications associated with the procedure.

I received information and discussed with my healthcare team the possible alternative methods of treatment, the risks related to not receiving the proposed treatment, and the likelihood that the proposed treatment will be successful. No guarantee or assurance has been made to me that this procedure will improve my condition. I also received information and discussed with my healthcare team the expected post procedural course and discomforts of the procedure.

I understand that because the University of Chicago Medicine (UCM) is a teaching institution, other physicians, including fellows and residents, in addition to APNs, PAs and medical students acting under the supervision and direction of my primary physician may perform important tasks related to the procedure. I also understand that qualified medical practitioners who are not physicians may perform important parts of the procedure or the administration of anesthesia that are within their scope of practice and for which they have been granted privileges by UCM.

CS

JAN 3 0 2018

AT THE FOREFRONT
UChicago Medicine

Patient Name: _____
MRN: _____
CSN: _____
AFFIX PATIENT IDENTIFICATION LABEL HERE

I authorize films, videos, photographs or other images or recordings of this procedure to be taken for medical, scientific, or educational purposes provided the pictures do not reveal my identity, and I am not identified by name.

I consent to the study and disposal by UCM of any tissues or body parts that may be removed. For the purpose of advancing medical education, I also consent to and authorize appropriate observers, including students in the health care professions, to be present in the procedure room.

I consent to UCM sharing my patient information with my other non-UCM health care providers through electronic portals and exchange, for the purpose of coordinating medical care. I understand that this would enable my non-UCM providers to access certain information in my medical record at UCM, including – if applicable – information relating to mental health, HIV/AIDs, genetic testing, Communicable Diseases (STDs), invitro fertilization, abuse, domestic violence, and drug and alcohol treatment information. I know that this process is voluntary and that I may "Opt Out" at any time by requesting an "Opt-Out" form.

CONSENT FOR BLOOD TRANSFUSION:

- I have been told that I may need a transfusion of blood or blood products and have been told the benefits and the risks of receiving blood or blood products.
- I have also received information about transfusion alternatives, including autologous (my own blood) and directed (donated for a specific patient) donations, intravenous iron infusions, and erythropoiesis stimulating agents (helps the body make red blood cells).

Benefits of Blood or Blood Product Transfusions:

- Life-saving treatment to improve the body's ability to carry oxygen and treat anemia that may otherwise result in organ damage or death
- Correction of diseases, conditions, or disorders that affect the body's ability to form blood clots and prevent bleeding

Risks or Consequences of Blood or Blood Product Transfusions:

- Uncommon (1-5% chance of occurring)
  - Mild allergic reaction resulting in rash, hives, or fever
- Rare (less than 1% chance)
  - Respiratory distress or lung injury resulting in shortness of breath or difficulty breathing
  - Acute kidney injury
  - Exposure to blood borne viruses such as hepatitis B, bacteria or parasites causing an infection
  - Decreased function of the immune system and the body's ability to fight infection
  - Shock
- Extremely Rare (One in a million or less chance)
  - Exposure to blood borne viruses such as hepatitis C or Human Immunodeficiency Virus (HIV) the virus that causes AIDS)
  - Death

Alternatives to Blood or Blood Product Transfusions

- Pharmacologic Agents

AT THE FOREFRONT
UChicago Medicine

[redacted]

CONSENT TO MEDICAL/SURGICAL PROCEDURES

I authorize [redacted] and whomever he/she may designate as
(Name of attending physician)

necessary to perform upon [redacted] the following procedure(s):
(Name of Patient)

central venous catheter ("central line")
(Name of procedure and description in lay language)

If any unforeseen condition arises in the course of the procedure calling in the physician's judgment for procedures in addition to or different from those now planned, I further request and authorize the physician to do whatever the physician deems medically advisable.

I consent to the administration of moderate sedation, deep sedation or general anesthesia and to the use of such medications as my physicians may deem advisable. The type and purpose of the sedatives, pain medications, and/or anesthetics, possible alternative methods of sedation or anesthesia, and the possibility of complications, including but not limited to the principle risks of decreased rate of breathing, low oxygen level, low blood pressure, changes in my heart rate and its rhythm, prolonged drowsiness, nausea and vomiting, breathing problems, getting stomach acid into my lungs and irritation to the vein where medication is given, have been fully explained to me.

I received information about my condition and the purpose of my treatment. I received information and discussed with my healthcare team the specific procedures to be performed, including the anticipated benefits and the material risks and possible side effects of the procedures. Some of the risks my physician discussed with me include: bleeding, infection, injury to lungs (pneumothorax) and adjacent structures

Additional risks and complications may occur. I understand that this document is not intended to include a list of all known risks and complications associated with the procedure.

I received information and discussed with my healthcare team the possible alternative methods of treatment, the risks related to not receiving the proposed treatment, and the likelihood that the proposed treatment will be successful. No guarantee or assurance has been made to me that this procedure will improve my condition. I also received information and discussed with my healthcare team the expected post procedural course and discomforts of the procedure.

I understand that because the University of Chicago Medicine (UCM) is a teaching institution, other physicians, including fellows and residents, in addition to APNs, PAs and medical students acting under the supervision and direction of my primary physician may perform important tasks related to the procedure. I also understand that qualified medical practitioners who are not physicians may perform important parts of the procedure or the administration of anesthesia that are within their scope of practice and for which they have been granted privileges by UCM.

CS

JAN 3 0 2018

AT THE FOREFRONT
UChicago Medicine

Patient Name: _____
MRN: _____
CSN: _____
AFFIX PATIENT IDENTIFICATION LABEL HERE

I authorize films, videos, photographs or other images or recordings of this procedure to be taken for medical, scientific, or educational purposes provided the pictures do not reveal my identity, and I am not identified by name.

I consent to the study and disposal by UCM of any tissues or body parts that may be removed. For the purpose of advancing medical education, I also consent to and authorize appropriate observers, including students in the health care professions, to be present in the procedure room.

I consent to UCM sharing my patient information with my other non-UCM health care providers through electronic portals and exchange, for the purpose of coordinating medical care. I understand that this would enable my non-UCM providers to access certain information in my medical record at UCM, including – if applicable – information relating to mental health, HIV/AIDs, genetic testing, Communicable Diseases (STDs), invitro fertilization, abuse, domestic violence, and drug and alcohol treatment information. I know that this process is voluntary and that I may "Opt Out" at any time by requesting an "Opt-Out" form.

CONSENT FOR BLOOD TRANSFUSION:

- I have been told that I may need a transfusion of blood or blood products and have been told the benefits and the risks of receiving blood or blood products.
- I have also received information about transfusion alternatives, including autologous (my own blood) and directed (donated for a specific patient) donations, intravenous iron infusions, and erythropoiesis stimulating agents (helps the body make red blood cells).

Benefits of Blood or Blood Product Transfusions:

- Life-saving treatment to improve the body's ability to carry oxygen and treat anemia that may otherwise result in organ damage or death
- Correction of diseases, conditions, or disorders that affect the body's ability to form blood clots and prevent bleeding

Risks or Consequences of Blood or Blood Product Transfusions:

- Uncommon (1-5% chance of occurring)
  - Mild allergic reaction resulting in rash, hives, or fever
- Rare (less than 1% chance)
  - Respiratory distress or lung injury resulting in shortness of breath or difficulty breathing
  - Acute kidney injury
  - Exposure to blood borne viruses such as hepatitis B, bacteria or parasites causing an infection
  - Decreased function of the immune system and the body's ability to fight infection
  - Shock
- Extremely Rare (One in a million or less chance)
  - Exposure to blood borne viruses such as hepatitis C or Human Immunodeficiency Virus (HIV) the virus that causes AIDS)
  - Death

Alternatives to Blood or Blood Product Transfusions

- Pharmacologic Agents

AT THE FOREFRONT
UChicago Medicine

[redacted]

I understand that pharmacologic agents will help my body to produce certain blood cells naturally, or may help my body to stop bleeding naturally. Examples include intravenous iron and erythropoiesis stimulating agents (helps the body make red blood cells), pro-thrombotic agents (helps the blood to clot) and anti-fibrinolytic agents (helps keep blood clots in place to stop bleeding).

- Intraoperative Cell Salvage
  It may be possible to collect my own blood lost during surgery and infuse it back to me in the Operating Room.

- Autologous or Directed Donor Donation
  It may be possible to donate my own blood before surgery or a planned transfusion. My donated blood may be used exclusively for me during my surgery (autologous donation); or my donation may be designated for specific person (directed donation).
  1. I acknowledge that my physician and his/her healthcare team have provided me with the information described above regarding my planned or potential blood transfusion or use of blood products.
  2. I have had a chance to ask my physician and his/her healthcare team about the transfusion process and its risks and consequences and he/she has answered them to my satisfaction.
  3. I understand this consent for blood transfusion or use of blood products is valid for my entire hospitalization or until I withdraw my consent for blood transfusions:

_____ (Patient Initials) I consent to the use of **ALL** blood products and blood fractions

_____ (Patient Initials) I consent to the use of **SPECIFIC** blood products and blood fractions and understand that I will be asked to sign a Refusal to Permit Blood Transfusion or Administration of Blood Products form specifying the product

_____ (Patient Initials) I **DO NOT** consent to the use of any blood products or blood fractions and understand that I will be asked to sign a Refusal to Permit Blood Transfusion or Administration of Blood Products form

I acknowledge that my physician and his/her healthcare team have provided me with the information described above regarding my surgery/procedure. I have had an opportunity to discuss the procedure and anesthesia with the physician(s) involved, I have been given an opportunity to ask questions and my questions have been answered.

[redacted] Date: 1/11/18 Time: 445
Patient or Representative Signature

[redacted]
Patient or Representative Printed Name

[redacted] Date: 1/11/18 Time: 16:24
Physician/PA/APN Signature

[redacted]
Physician/PA/APN Printed Name

JAN 3 0 2018

FORM 29.41 R8/14

[redacted]

1. I authorize Dr. Le (name of attending physician) and whomever he/she may designate as necessary to perform upon [redacted] (printed name of patient) the following procedure(s):

   EXAMINATION OF THE ESOPHAGUS, STOMACH AND SMALL INTESTINE WITH A LIGHTED FLEXIBLE TUBE WITH POSSIBLE TISSUE SAMPLING (BIOPSY AND/OR CYTOLOGY), AND/OR POLYP REMOVAL; and if any unforeseen condition arises in the course of the procedure in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems medically advisable.

2. The following have been fully explained to me: the nature of my condition, the nature and purpose of the procedure, possible alternative methods of treatment, the probability that the proposed treatment will be successful and the prospect of recovery if no treatment is received, risks and complications. The risks of the procedure include, but are not limited to: **unexpected medication reaction, aspiration, perforation, and bleeding.** No guarantee or assurance has been made as to the results that may be expected.
3. I consent to the administration of conscious sedation and to the use of medications as the physician deems advisable. The nature and purpose of conscious sedation and the possibility of complications have been explained to me.
4. I have had the opportunity to discuss the procedure and conscious sedation with the doctor or doctors involved and I have been given an opportunity to ask questions and my questions have been answered.
5. I consent to the use, study and/or disposal by the University of Chicago Medicine (UCM) of any tissue which may be removed.
6. I consent to the taking and publication of any photographs, videos or other recordings in the course of the procedure for the purpose of advancing medical education, research or science, and/or to document pathology.
7. For the purpose of medical education, I consent to the admittance of observers to the procedure room.
8. **I have read and understand this form and agree with all statements therein.**

Patient Signature [redacted] Date 1/22/18 Time 3:12pm

Patient Printed Name [redacted]

Patient Representative _____ Date _____ Time _____

Relationship to Patient _____

Patient Representative Printed Name _____

Witness to Signature _____ Date _____ Time _____

Licensed Physician Signature Explaining and Obtaining Consent [redacted] Date 1/22/18 CS Time 3:12pm

Licensed Physician Printed Name [redacted]

JAN 30 2018