

## CONSENT FOR ENDOSCOPY PROCEDURES

DOCTOR(S):

FRANKLIN KASMIN

has/have discussed my medical problem with me and has/have explained in lay terms the following procedure(s) to be undertaken in the course of my treatment:

- |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Flexible sigmoidoscopy, Possible Biopsy, Possible Polypectomy<br><input type="checkbox"/> Colonoscopy with Possible Biopsy and Polypectomy, Heater Probe Coagulation and/or Sclerotherapy of Bleeding Sites<br><input checked="" type="checkbox"/> Esophagogastroduodenoscopy With Possible Biopsy, Polypectomy, Esophageal and Pyloric Dilatation, Heater Probe and/or Sclerotherapy of Bleeding Sites | <input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography With Possible Stone Extraction, Papillotomy, Stent Placement, Biopsy and Polypectomy, Nasobiliary Tube Insertion.<br><input type="checkbox"/> Percutaneous Endoscopic Gastrostomy (PEG)<br><input type="checkbox"/> Esophageal Dilation <input type="checkbox"/> Enteroscopy <input type="checkbox"/> Bronchoscopy<br><input type="checkbox"/> Nasal Endoscopy <input type="checkbox"/> Laryngoscopy <input type="checkbox"/> PEG Tube Exchange |
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☒ Other: ENDOSCOPIC ULTRASOUND, AXIAL STENT

1. I have been fully informed and understand the potential benefits, risks and side effects of this care and also the likelihood of achieving goals related to this procedure. Any potential problems that might occur during recuperation have been explained to me. I have also been informed about reasonable alternatives and the risk of not receiving this procedure.
2. My physician has fully informed me of and I understand the potential risks and the possibility of complications, and medically acceptable alternatives to the above-described procedure(s), and I understand that I may refuse to undergo such procedure(s). These risks and complications include:
  - Pneumothorax or Collapsed lung, Air Embolus
  - Possible soreness, inflammation, or phlebitis of the intravenous ("IV") site.
  - Injury to the digestive tract by the instrument which may result in perforation of the bowel wall with leakage of intestinal juices into body cavities. If this occurs, surgery to close the leak and/or drain the region may be necessary.
  - Bleeding which, if occurs, is usually a complication of biopsy, polypectomy, or dilation. Management of this complication may consist of only careful observation or may require a blood transfusion, or possibly a surgical operation for control.
  - 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 very low frequency. Any of the complications could lead to death.
3. I understand the risks and consent to the administration or transfusion of blood or blood components to me during my procedure and/or its related treatment whenever deemed necessary by those physicians attending me, with no warranties made in connection with such blood or blood components.
4. If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request the physician and/or his other associate(s) to take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
5. I consent to the proposed procedure(s) by the above physician(s) and (their) associates. I consent to the disposal by hospital authorities of any tissue or parts which may be removed in connection with my procedure(s). Tissues and/or organs, no longer needed for diagnostic purposes, may be used and/or photographed for research and educational purposes at Aventura Hospital and Medical Center, and its teaching facilities or for publication in an article related to medical research for the purpose of medical education.
6. I consent to the taking of photographs or recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician(s) and to the admittance of qualified observers to the procedure room as determined by the hospital.
7. I have been made aware and acknowledge that the practice of medicine is not an exact science and that no guarantee or assurances have been made to me regarding expected outcomes.
8. I have been fully informed of and consent to the use of Moderate Sedation. I have been explained the risks, benefits and possibility of complication, if it is applicable for my procedure.

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I have read and understand all of the above, have had an opportunity to ask questions my planned procedure(s), and my questions have been answered to my satisfaction.

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[Signature]  
Signature of Patient

[Redacted]  
Print Name

10/12/19 1517  
Date Time

[Signature]  
Witness (Signature & Title)

FERNANDO B. CROCKER 10/12/19 1517  
Print Name Date Time

If patient is unable to consent or is a minor, complete the following: Patient is unable to consent because

\_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness (Signature & Title)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Time

\_\_\_\_\_  
2nd Witness (if applicable) (Signature & Title)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Time

[Signature]  
Physician Signature

[Signature]  
Print Name

10/12/19  
Date Time

If Language Line used, Language Line Operator Certificate Number \_\_\_\_\_

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