OR2C261 Stony Brook, NY 11794

[redacted]

CONSENT TO OPERATION OR PROCEDURE AND ANESTHESIA

I request and consent to a surgical procedure called **UPPER ENDOSCOPY** WITH POSSIBLE BIOPSY AND/OR REMOVAL OF POLYPS/LESIONS, DILATION, ABLATION OF LESIONS, BANDING/SCLEROSIS OF VARICIES, REMOVAL OF FOREIGN BODY, STENT PLACEMENT/REMOVAL, ENDOSCOPIC MUCOSAL RESECTION, BLEEDING CONTROL AND ANY OTHER INDICATED URGENT PROCEDURE WARRANTED.

and I understand that the purpose of this procedure is
TO EVALUATE THE LINING OF THE ESOPHAGUS, STOMACH, FIRST PART OF THE SMALL INTESTINE. POSSIBLE BIOPSY AND/OR REMOVAL OF LESIONS, DILATION, ABLATION, BLEEDING CONTROL, FOREIGN BODY REMOVAL.
This procedure will be performed by **DR.** TOBEN **and associates**

I have been advised that this procedure may have potential benefits, risks and side effects including but not limited to

BLEEDING, PERFORATION, POSSIBLE NEED FOR SURGERY, MISSED POLYPS/LESIONS/CANCER, ABDOMINAL DISCOMFORT, STENT MIGRATION, LOW BLOOD PRESSURE, RESPIRATORY FAILURE, ALLERGIC REACTION, INFECTION.

I have been advised of the alternatives, benefits and side effects related to the alternatives. I have been advised of the likelihood of achieving my goals and any potential problems that might occur during recuperation.

- ~~I consent to the administration of anesthesia and related drugs, as deemed necessary by the staff members from **Stony Brook Anaesthesiology, UFPC.**~~
- I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.
- I understand that portions of the operation/procedure may be photographed or videotaped. I understand that every attempt will be made to conceal my identity. I understand that some of these photograph/videotapes may be used for teaching and may not be maintained or be a part of my medical record. I also understand that photographs/videotapes to plan, monitor or document my treatment may be part of my medical record.
- I understand that residents, medical, nursing and allied health students/trainees may be present during the procedure and they may observe or assist in my care, under the direction of my surgeon and/or other hospital staff members.
- I understand that a sales/clinical representative may be present during the procedure, but may not participate in the procedure.
- I impose no specific limitations or restrictions on my treatment **unless** written below:

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

X [redacted] 1/4/19

Signature of Patient or authorized representative **Relationship (if other than Patient)** **Date**

***If other than Patient, provide a reason**

X [redacted] 0808 1/4/19

Signature of Witness **Title or Relationship to Patient** **Time** **Date**

(Age 18 or older, other than Practitioner performing procedure)

An interpreter or special assistance was used _____ _____
(Name of Interpreter) ID# as applicable

I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, potential problems during recuperative phase, treatment and services, and possible results of not receiving care.

X [redacted] 144552 [redacted] 1/4/19

Signature of Practitioner **ID#** **Time** **Date**

COMPLETED CONSENT FORM VALID UP TO FOUR MONTHS