REQUEST FOR DIAGNOSTIC/OPERATIVE PROCEDURE/TREATMENT

This is an agreement between Dr. _____ and me summarizing our discussion and my understanding of the conditions under which we mutually consent to undertake treatment. I understand my physician will use his/her best skill and judgment to accomplish the desired result, but also that he/she cannot and does not warrant or guarantee such a result. Also, his/her forecast of manner of recovery and possible complications is based upon usual or average response in a case similar to mine, but not a promise as my response may differ from the usual.

I, _____, request and authorize Dr. _____

and associates of his/her choice to perform **Esophagogastroduodenoscopy with possible dilation, polypectomy, with or without biopsy** and administration of moderate sedation on _____ (date).

Prior to sedation we have discussed my current health status, the purpose and nature of procedure, the hoped for results, and acceptable alternatives to the procedure named above, which include no examination and doing nothing. The risks of the procedure which include bleeding, perforation, missed lesions have been explained to me and I have been given the opportunity to have my questions answered by the physician.

I understand that the administration of moderate sedation, as with all medical treatment, includes serious risks which cannot be eliminated. However, my physician will evaluate my medical and surgical condition and choose the sedation course which best meets my needs. I have had the opportunity to obtain answers to all questions I have regarding moderate sedation.

I authorize removal and disposal of tissue as indicated in the course of this procedure.

I authorize taking of photographs for educational reasons.

I authorize release of information by Michiana Endoscopy Center Inc. to any third party responsible for my account.

I understand that any Advanced Directives that I have will not be honored within the Center in the event of a life threatening event. Emergency medical procedures will be implemented, my medical condition will be stabilized and I will be transferred to an acute health care facility where the decision to continue or terminate measures can be made by my attending physician and family.

Patient or Legal Guardian Signature_____

Relationship to Patient _____Date_____Time_____

Witness to Signature_____

I have explained to the patient prior to sedation the above procedure, the potential benefits, any alternatives and the possible complications and risks.

_____	_____	_____
Signature of Physician	Date	Time

MICHIANA ENDOSCOPY CENTER
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