

**Authorization for Surgery and/or Special Procedure/Treatment**

**Patients Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

I authorize Dr. AJIT KOKKAT to perform the following surgery and/or special procedure/treatment:

UPPER ENDOSCOPY with possible biopsy/balloon dilatation/banding/polypectomy/hemostasis

\_\_\_\_\_ and any other indicated procedures.

And if applicable, I also authorize \_\_\_\_\_ for the purpose of performing the following significant medical/surgical tasks as part of the surgery and/or special procedure/treatment:

Dr. AJIT KOKKAT has explained:

- The nature, purpose, and benefits of the proposed surgery/procedure/treatment
- The foreseeable risks and consequences of the proposed surgery/procedure/treatment, including
  - Any potential problems that may occur during recuperation
  - The risk that the proposed surgery/procedure/treatment may not achieve the desired objective.
- The alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives.
- The following specific risks of the surgery and/or special procedure:

- I understand that no guarantee has been made about the results of the proposed treatment or special procedure and those questions about the proposed surgery/procedure/ treatment/ have been answered
- I agree to the use of anesthesia and/or sedation/analgesia as required
- I agree to the use of local or topical analgesia as required
- I agree if applicable, to the disposal of any tissue removed
- I also authorize permanent image documentation of my surgery. In addition, documentation images may be used for scientific or educational purposes provided my identity is protected. I agree that any images may be disposed of by River Valley ASC
- I understand that all Do No Resuscitate orders are suspended until I am fully recovered from anesthesia and discharged from the Post Anesthesia Care Unit. If I do not agree with this, my wishes must be documented in the chart and agreed to by the surgeon and anesthesiologist

This consent may be withdrawn by me at any time, prior to the surgery/procedure/treatment.

**Signature Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

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

**Signature of physician obtaining informed consent** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Witness** \_\_\_\_\_ **Date** \_\_\_\_\_