TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. ______________________________as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to ***treat*** my condition which has been explained to me as: ___________________________

____

Other health care providers will be ____

who will ☐ open and close incision, dissect, remove and/or alter tissue ☐ harvest grafts ☐ implant devices ☐ other __________________

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and ***authorize those procedures.***

Esphagogastroduodenoscopy (EGD) with Possible Biopsy and/or Possible Esophageal Dilatation and/or Foreign Body Removal

I (we) understand that my physician may discover other or different conditions which require ***additional or different procedures*** than those planned. I (we) authorize my physician, and such associates and other health care providers to perform such procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be ***risks and hazards*** in continuing my present condition without treatment, there are also risks and hazards to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also understand that the following risks and hazards may occur in connection with this particular procedure:

Bleeding   Infection   Aspiration   Perforation   Adverse Drug Reaction   Heart or Breathing Problems

I (we) understand that ***anesthesia involves additional risks and hazards*** but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) understand that certain ***complications*** may result from the use of anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other ***risks and hazards*** which may result from the use of general anesthetics ranges from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include head ache, chronic pain, bleeding and/or infection. I (we) have been given an ***opportunity to ask questions*** about my condition, ***alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved,*** and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) authorize the hospital pathologist to use his/her discretion in the disposal of removed patient tissue.

I (we) (do)_____(do not)_____authorize the Medical Center of Plano and/or surgeon to photograph/video or permit other persons to photograph/video me during surgery and use the photograph/video for such purposes as may be deemed necessary, providing my identity is not revealed by descriptive texts accompanying the pictures.

I (we) (do) _____(do not)____consent to the presence of ____________________________________ in the operating room to observe the procedure. I (we) understand that only the surgeon may grant permission on my (our) consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in; and that I (we) understand its contents. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the procedure(s) to be done.

________________	________	________	________________	________	________	________
Patient's Signature	Date	Time	Other Legally Responsible Person's Signature	Relationship	Date	Time

________________	________	________	3901 W. 15th St. Plano Texas 75075
Witness Signature/Title/Position	Date	Time	Witness Work Address

I have provided the patient/parent/guardian with information on risks, benefits, and alternatives to treatment and side effects including potential problems related to recuperation as outlined in the above within my area of expertise.

______________________________________ Date __________________ Time ________________

Signature of Physician Obtaining Consent

The Medical Center *of* Plano

3901 West 15th Street • Plano, Texas 75075

EGD with Possible Biopsy, Esophageal Dilation, Foreign Body Removal

TREAT

PATIENT IDENTIFICATION

C-003 (Rev 11/09) MAC 353