Atlantic Digestive SPECIALISTS
Helping people inside & out

SAMPLE ~ STANDARD CONSENT FORM

Request for Procedure/Surgery

Your physician will review with you *the day of your procedure.*
Once all of your questions have been answered, you and your physician will sign the form prior to your procedure.
If you have any question, please contact the clinical department at: Portsmouth 603-433-2488 Somersworth 603-692-2228

Planned Procedure/Treatment:_____

_____

Diagnosis/Reason for Procedure/Treatment: check colon for growths, source of blood, biopsy and remove lesions.
This procedure will be performed by_____ and/or his/her associate(s) and any assistants he/she designates.

I have been advised of the risks, complications or adverse consequences associated with this procedure including, but not limited to, puncture bowel, possible need for surgery, heart and lung problems, infection, bleeding, loss of use of body parts, cardiac arrest and death._____

(Practitioner may include additional procedure-specific information here)

The above procedure has been fully explained. I have been advised about the reasonable risks and benefits to be expected as compared with any alternative treatments available to me. 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 the professional judgment.

I REQUEST THE ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS IF NECESSARY IN THE JUDGEMENT OF THE ANESTHESIOLOGIST OR SURGEON. I understand the potential need for a blood transfusion and available alternatives. I understand that the transfusion of blood is associated with risks that cannot be completely avoided, even by the most careful modern blood banking techniques. These risks include, but are not limited to transmission of infectious disease, particularly hepatitis and acquired immune deficiency syndrome, and the possibility of severe transfusion reactions. These reactions may produce fever, hives, or more serious reactions such as shock and/or kidney shutdown.

If the administration of local anesthetics, sedatives and painkillers is deemed necessary in the judgment of the physician performing the procedure, I understand this will produce a general state of sedation during the procedure; and the potential complications of these medications can include lowering of blood pressure, reduction in breathing and blood oxygen, airway obstruction, and hearth rhythm disturbances.

I also understand that portions of the procedure may be photographed or videotaped and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication. I also understand that observers may be present during the procedure. I impose no specific limitations or restrictions on my treatment.

I authorize the physician(s) performing the procedure and the hospital to preserve any body fluids or tissues removed during the procedure or treatment for scientific or teaching purposes, to use in the treatment of other patients or to dispose of any tissues, body parts or organs removed as a necessary part of my treatment in accordance with acceptable medical practices.

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 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. All blank spaces have been either completed or lined out prior to my signing this document. I have been informed that I can change my mind and withdraw consent at any time before the procedure or treatment.

_____	_____	_____	_____
Signature of Patient, Parent, Guardian, Health Care Agent or other Representative of Patient (if other than patient)	Relationship	Date	Time

Statement of Practitioner Obtaining Consent:
I certify that I have explained to the patient the risks, benefits and alternatives of this procedure as well as the probable consequences of receiving no treatment. I have answered all of his/her questions.

_____	_____	_____
Signature of Practitioner	Date	Time