Green Mountain Surgery Center

Patient Label

I hereby authorize Dr._____ and his/her associates/assistants to perform a **Gastroscopy, possible biopsy, possible dilation**.

- I understand the nature of the procedure to be the passage of a lighted flexible instrument through the mouth, esophagus, stomach, and duodenum, to examine the lining of these organs, to do biopsies if necessary, or to perform endoscopic therapy as may be indicated.
- I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks include but are not limited to bleeding, infection, pneumonia, reaction to the medication used for sedation, perforation of the esophagus, stomach, or duodenum, possibly requiring an operation to repair.
- I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
- I acknowledge that the reasonable alternatives of the proposed procedure have been explained to me.
- I understand that a Gastroscopy is not completely accurate and occasionally abnormalities including cancers and polyps may be missed.
- The risks, benefits and alternatives of sedation have been explained to me and I consent to sedation. If the nature of the procedure(s) requires an anesthesiologist I consent to the administration of anesthesia to be administered under the direction of a member of the Anesthesiology Department.
- If I receive sedation, I understand the importance of avoiding driving and performing activities that might be dangerous to myself and others.
- I authorize my physician and the laboratory to which any specimens will be sent to dispose of any specimens removed as a result of the procedure, or to preserve said specimens at their discretion for scientific or teaching purposes.
- I acknowledge that I have been given the opportunity to ask questions concerning this procedure and that my questions, if any, have been answered to my satisfaction.
- I acknowledge that I have read this document in its entirety, and that I fully understand it.

By signing below, I am agreeing to all of the above, except as follows:

_____

_____ _____

Patient Signature Date **Physician Signature Date**