Meridian Health System

JERSEY SHORE MEDICAL CENTER

# SPECIAL CONSENT TO OPERATION OR OTHER PROCEDURE

0195-003JX (9/97)

Imprint Area

Patient: _____ Date: ____/____/____ Time: ____:____ a.m. / p.m.

1. I hereby authorize Dr. _____, ("physician") and such assistants as may be selected to treat the following condition(s): _____

2. **A.** The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr. _____, and I understand the nature of the procedure to be (check where applicable):

- ☐ **Flexible Sigmoidoscopy (insertion of tube into rectum / colon) with possible biopsy (tissue sample)**
- ☐ **Colonoscopy with possible biopsy (tissue sample) or polypectomy (polyp removal) (insertion of tube into rectum / colon)**
- ☐ **EGD with possible biopsy (tissue sample) / cautery / dilation (insertion of tube into stomach)**
- ☐ **ERCP with possible sphincterotomy (incision) / stent or drain insertion / stone removal (insert tube into stomach and inject dye into the bile/pancreatic duct)**
- ☐ **Sclerotherapy / Banding (inject / band veins in esophagus)**
- ☐ **Percutaneous Endoscopic Gastrostomy - PEG (insertion of feeding tube through abdominal wall)**
- ☐ **Percutaneous Liver Biopsy (tissue sample)**
- ☐ **Bronchoscopy with Biopsy**
- ☐ **Tee**
- ☐ **Laser**

**B.** It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

**Contrast Radiographic Studies (Barium Enema or GI Series)**
**Observation (not to do the procedure)**
**For PEG: Surgical Gastrostomy**
**For ERCP: Surgical Exploration**
**For Sclerotherapy / Banding: Surgery and/or medication**
**For Percutaneous Liver Biopsy: Surgical liver biopsy**
**For Bronchoscopy / Open lung biopsy / CT needle biopsy**

**C.** I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

**Bleeding (increase if biopsy, polypectomy or sphincterotomy is performed)**
**Perforation (tear a hole inside possibly requiring surgery to be performed)**
**Aspiration (fluid entering the lungs)**
**ERCP: Inflammation of bile or pancreatic ducts or infection**
**Liver Biopsy: Peritonitis (infection) / perforated organ**
**PEG: Peritonitis (infection) / skin infection / perforated organ**
**Bronchoscopy - Pneumothrorax (collapse of lung) - Infection**

**D.** I have been told that if the procedure is not performed, what may happen to me is:

**The condition listed above may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding/tumor or growth/disease)**

**E.** It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgement. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the operation or other procedure commenced.

**F.** I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest, etc., that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

**G.** I consent to the administration of anesthesia and the use of such anesthetics as may be deemed advisable by the physician or anesthesiologist responsible for this service to me. The anesthesiologist is not necessarily a physician as named above in #1 above. Benefits and risks of anesthesia have been explained. Risks include, but are not limited to changes in heart rate, breathing and/or blood pressure or inflammation at site of injection.

**H.** I consent to the retention or disposal of any tissue or parts which may be removed.

**I.** I certify that I have read and fully understand the above consent to operate procedure(s); that the explanations therein referred to were made to me by Dr. _____, and that the statements requiring insertion or completion were filled in and paragraphs which I do not want to apply, if any, were stricken before I signed.

_____ *Witness to signature*

_____ *Signature of patient or other person responsible*

_____ *Witness to signature*

_____ *Relationship when patient is unable to sign or is a minor*

## PHYSICIAN'S CERTIFICATION

I, Dr. _____, certify that I have explained the specified operation(s) or procedure(s), the attendant risks and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, plus the sedation, its risks, benefits and alternatives, to the above named patient and/or other responsible person who has signed the above consent.

_____ *Date*

_____ D.O./M.D.
*Physician*