Endoscopy Center of Ocean County / Endoscopy Center of Toms River
Doctors Tamimi, Collier, Bigornia, Glazier, Mirchandani
477 / 473 Lakehurst Road
Toms River, New Jersey 08755
732-349-4422

INFORMED CONSENT FOR ENDOSCOPY PROCEDURE

I, _____, authorize the performance upon myself by Doctors Tamimi / Collier / Bigornia / Glazier and/or Mirchandani of the following procedures:

a) Colonoscopy with possible biopsy and/or possible polypectomy
b) Upper Panendoscopy with possible biopsy, possible dilatation
c) Flexible Sigmoidoscopy with possible biopsy and/or possible polypectomy
d) Small bowel Enteroscopy and possible biopsy

Doctor Tamimi / Collier / Bigornia / Glazier / Mirchandani have determined that a colonoscopy / upper panendoscopy / flexible sigmoidoscopy is an indicated procedure for my medical care. This involves looking into the colon or stomach with a lighted flexible tube and possible removal of specimens for analysis.

I am aware that although colonoscopy / upper panendoscopy / flexible sigmoidoscopy, is generally a very safe procedure, there are unusual cases when complications may occur. These include reaction to medication, such as allergic reactions, excessive lowering of blood pressure and suppression of breathing. Perforation or puncturing of the esophagus, stomach or colon may necessitate surgery. Hemorrhage would possibly require blood transfusion or surgery. As required by law, I have been made aware of the option to donate my own blood or designate a donor prior to the endoscopy in case a blood transfusion should become necessary as a result of a complication of the procedure. Death is an extremely rare occurrence.

Written instructions have been given to me regarding this procedure. I have read them and understand these instructions fully and will comply with them.

To the best of my knowledge, all the answers to the questions I have been asked are true and I have not withheld any information.

A copy of Patient Rights has been provided to me.

The advantages and disadvantages of outpatient endoscopy have been explained to me and I understand them. I realize that following my procedure, admission to a hospital might be necessary. I agree to be transferred to, and possibly admitted, to Community Medical Center, if my doctor decides it is necessary.

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 as to the result of the operation(s) or procedure(s).

I wish to advise that I (do) (do not) have a Living Will, Medical Power of Attorney, or Advance Medical Directive. I have been informed that the Endoscopy Center does not honor Advance Directives. In the unlikely event my health status requires emergency treatment; the Endoscopy Center will provide me with prompt emergency care until EMS arrives to transport me to Community Medical Center for further treatment. The hospital will be provided with information about my Living Will.

I have read this informed consent for the proposed procedure and all my questions have been answered.

I hereby consent to the proposed procedure, to the taking of photographs for the purposes of documentation, and the administration of the necessary preoperative medication as may be considered necessary or advisable by the physician.

SAMPLE ONLY- DO NOT SIGN

_____ _____
DATE / TIME SIGNATURE OF PATIENT OR GUARDIAN

_____ _____
WITNESS SIGNATURE OF PHYSICIAN