AtlantiCare SURGERY CENTER

AUTHORIZATION AND INFORMED CONSENT

1. I request that Dr. John Tung and/or such assistants as may be selected by him or them, perform the following procedure(s) upon me.

GASTROSCOPY

Using a soft flexible lighted tube swallowed orally (through the mouth) to examine the upper digestive organs: esophagus (swallowing tube to the stomach), stomach, and duodenum (part of the small intestine). Biopsies (bits of tissue) may be taken for testing, and/or if found, polyps (growths) may be removed (via one or more various techniques). Coagulation of bleeding vessels may be done. Dilation (stretching) of the esophagus may be necessary during the procedure. Intravenous sedation will be given for this procedure. Common risks associated with this procedure may include, but are not limited to, bleeding, infection, missed lesion, perforation of an organ, and death.

(*a description of the procedure in common language*)

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_____

2. The procedure(s) listed above has been fully explained to me, and I understand the nature of my medical condition(s), the nature and risks of the procedure, the expected results of the procedure and the available alternatives to this procedure.
3. I consent to the administration of such anesthesia as may be deemed necessary or advisable in the judgment of the physician-anesthesiologist.
4. I recognize that, during the course of the operation, unforeseen conditions may require additional or different procedures other than those listed. Should this occur, I ask that the above named physician or his assistants perform such procedures as are, in his professional judgment, necessary and desirable. This authority shall extend to treating conditions that are not known to my physician at the time the operation is begun.
5. I further consent to the administration of blood or blood components if it should become necessary. I understand that this involves a risk of viral hepatitis or other reaction.
6. I consent to the taking and use of photographs in the course of the operation for scientific and teaching purposes.
7. I authorize AtlantiCare Surgery Center to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimen or tissues taken from my body during the operation.
8. I know that the practice of Medicine and Surgery is not an exact science and that physicians cannot guarantee results. I recognize that no guarantee has been made by anyone regarding the operation which I have authorized.
9. I consent to the possible presence of medical technology representative(s) during my procedure.

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_____ _____

Witness to Signature Signature of Patient

If patient is a minor or unable to sign, please complete the following: Patient (is a minor _____years of age) is unable to sign because:

_____

_____ _____

Witness to Signature Signature of relative or legal guardian

10. As the physician responsible for performing the procedure(s), I have advised this patient of the nature of the proposed and alternative procedures(s), attendant risks involved and expected results as described above.

Date_____ Time _____AM/PM _____

Signature of Physician