

**CHAMBERSBURG ENDOSCOPY CENTER, LLC**

835 Fifth Avenue, Chambersburg, PA 17201

Date of Procedure: \_\_\_\_\_

**Consent for Surgery/Invasive Procedure**

*(Do **not** sign without reading)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M.  
P.M.

\_\_\_\_\_ will be performing a flexible sigmoidoscopy under sedation/analgesia  
Name of Physician  
and/or total IV anesthesia with performance of polyp removal and/or biopsies as necessary.

\_\_\_\_\_ It has been explained to me how the procedure will be done and what to expect.  
Yes

\_\_\_\_\_ It has been explained why this procedure was recommended to me.  
Yes

\_\_\_\_\_ It has been explained the available alternatives and choices to this procedure, as well as the risks of not having the procedure  
Yes done. These include but are not limited to: Colonoscopy, Barium enema, doing nothing. I have been fully informed in  
general terms of the risks, benefits, and alternatives associated with having the procedure at Chambersburg Endoscopy Center  
instead of a hospital.

\_\_\_\_\_ I have been provided an explanation of the known and recognized risks to this procedure.  
Yes

Specific risks include but are not limited to: bleeding and perforation (uncommon), heart attack, stroke, breathing  
difficulties or medication reaction (rare complications).

\_\_\_\_\_ I have had an opportunity to ask questions.  
Yes

\_\_\_\_\_ I have had my questions answered and I believe I have all the information I need to fully agree to this procedure.  
Yes

\_\_\_\_\_ I have read and understand this form and truthfully answered all questions.  
Yes

\_\_\_\_\_ I consent to the procedure.  
Yes

\_\_\_\_\_ Patient Self-Determination Act of 1990/Advance Directives: Chambersburg Endoscopy Center has made available to me  
Yes written information on my rights and responsibilities to make health care treatment decisions in compliance with the Patient  
Self-Determination Act of 1990. I also understand that I am consenting to have an elective procedure performed upon me at  
this facility; therefore, Chambersburg Endoscopy Center will not honor Advance Directives (Living Wills).

\_\_\_\_\_ Personal Valuables: Chambersburg Endoscopy Center provides facilities for the safekeeping of any valuables and any  
Yes valuables kept by the patient are kept at the patient's risk. I hereby accept full responsibility for any personal effects taken to  
the procedure room, including such things as dentures, eyeglasses, contact lenses, hearing aids.

\_\_\_\_\_  
Signature of patient or person authorized to consent for patient

\_\_\_\_\_  
Signature of Witness

I certify that the patient/parent/guardian or other legally responsible person has been provided information on the risks and hazards,  
Benefits and alternatives to treatments outlined above, had questions within my area of expertise answered and has given consent.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Physician