CHAMBERSBURG ENDOSCOPY CENTER, LLC
835 Fifth Avenue, Chambersburg, PA 17201

Consent for Esophagogastroduodenscopy
(*Do **not** sign without reading*)

Name: _____ Date: _____ Time: _____ A.M. P.M.

_____ will be performing an esophagogastroduodenoscopy under sedation/analgesia
Name of Physician
and/or total IV anesthesia with possible biopsies, treatment of bleeding source, and/or dilatation of stricture if indicated.

____ Yes 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 done. These include but are not limited to: Upper GI x-ray study. I understand in the event of a stricture that there are no alternatives for treatment and my symptoms will likely continue if a dilatation is not performed 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.

____ Yes I have been provided an explanation of the known and recognized risks to this procedure. Specific risks include but are not limited to: risk of aspiration pneumonia, bleeding, and perforation (uncommon risk), heart attack, breathing difficulties or medication reaction (rare complications.).

____ Yes 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 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. If I have an Advance Directive and an untoward event occurs, Chambersburg Endoscopy center will stabilize and transfer me to Chambersburg Hospital.

____ Yes Personal Valuables: Chambersburg Endoscopy Center provides facilities for the safekeeping of any valuables and any 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