1015 S. Hackett Rd.
Waterloo, Iowa 50701
319.234.5990

CedarValleyGI.com

CEDAR VALLEY
Digestive Health Center

Procedure Consent

I authorize the provider selected below to perform the following test/treatment/procedure: (name of test/treatment/procedure in the patient's own words):_____

_____

□ Ravi Mallavarapu, MD □ Srinivas Kalala, MD □ Moaz Sial, MD □ Shima Ghavimi, MD

□ Richard Manfready, MD □ Kavan Patel, MD □ Anjana Aggarwal, MD

□ Dileepa Pathirannehelage, MD □ Taha Ashraf, MD

Name of the test/treatment/procedure in medical terms (health care worker to fill in):

□ Colonoscopy □ Esophagogastroduodenoscopy □ Flexible Sigmoidoscopy
□ Paracentesis □ Liver Biopsy □ Endoscopic Ultrasound (EUS)

By signing this form, I understand and acknowledge that I have been informed of the following:

1. My medical condition has been explained to me by my provider.
2. The reasons for and the purpose of the recommended test/treatment/procedure has been explained to me.
3. The nature of the recommended test/treatment/procedurehas been explained to me.
4. The risks and benefits of the recommended test/treatment/procedure have been explained to me.
5. The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
6. All of my questions about the recommended test/treatment/procedure have been answered to my satisfaction.

By signing this form, I acknowledge and understand:

1. That the practice of medicine is not an exact science, and that no guarantees have been made to me as to the results of the test/treatment/procedure. I also understand that complications may occur which are beyond the control of the provider.
2. That unforeseen conditions my arise during the test/treatment/procedure. I agree that additional, necessary procedures may be performed based on intraprocedural findings and the provider's clinical judgement. Possible procedures with a reasonable likelihood of needing to be performed have been discussed with me.
3. The risks, benefits and alternatives to the type and method of anesthesia/sedation have been explained to me. My questions about the anesthesia/sedation have been answered to my satisfaction, and I consent to the administration of such anesthesia/sedation medications as may be considered necessary or advisable by my physician.

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- That the provider may remove tissue or biopsies during the test/treatment/procedure.
- That I may be given a substance during an x-ray to make my body tissue easier to see.
- That pictures or videos of my test/treatment/procedure may be taken, if my provider thinks it is needed for medical reasons.
- That someone may watch or help with my test/treatment/procedurefor medical teaching purposes.
- That if my provider thinks I need **blood or blood products** for medical reasons, **it will be given.**

I have read the above consent form. I understand the Risks, Benefits, and Alternatives of the test/treatment/procedure. I authorize my provider to perform the recommended test/treatment/procedure.

Patient Signature	Date	Time
Witness Signature	Date	Time

This section is for a minor patient, or patient without legal rights to sign the consent. Signature below must be from a person who has legal right to consent for the patient.

Signature of Legal Representative to Patient	Date	Time
Relationship to Patient		
Witness Signature	Date	Time

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