35256
CH-1096 (JAN 12)
Effective 2012

Indiana University Health

CONSENT FOR PROCEDURE

[redacted]

By signing this form, I agree to the procedure(s) listed here. esophagogastroduodenoscopy with biopsies and colonoscopy with biopsies

to be done by Dr. [redacted] or colleagues members of Indiana University Health medical or other licensed personnel staff.

From this point on
- all procedures will be called the "procedure"; and
- the persons performing the procedure will be called "treating practitioner".

The exceptions to my consent are as follows:

I understand and agree to the following items.
- Residents and students may help with my care.
- Medical staff other than the treating practitioner may do part of my procedure.
- Industry representatives may be in the room to consult during my procedure.
- The treating practitioner may do other procedures not listed here if they are needed.
- A bad outcome may occur. A bad outcome does not mean care was not appropriate.
- The anesthesiologist or treating practitioner will give me an anesthetic. I have been told about the risks of anesthesia. These include death, injury to my teeth, throat and mouth, other injury and damage to my dentures.
- I agree to get blood and/or blood products any time during this hospital stay if the treating practitioner thinks I need it. I have been told about the risk of getting blood. I have been told if there are other choices. If I need blood or blood products, I agree to the risks that include allergic reactions, infections (hepatitis and AIDS), intravascular fluid overload, and chemical imbalances.
- Parts of my body taken out during surgery can be thrown away or used for research so long as my name is not used.
- Pictures may be taken and used for teaching as long as my name is not used.
- I have talked with the treating practitioner about the procedure, why I need it, the expected outcome, the risks, the chances of success, risks, benefits and results of other treatments, and what could happen if I do not have the procedure.
- I have been told about other choices, including not having the procedure, other procedures, medicine, and therapy.
  Other choices: _____
- I have been told about the risk of the procedure, which include but are not limited to bleeding, infection, injury, scarring, damage to parts of my body, and death. Other risks: _____

[redacted]
Signature of Patient/Surrogate

3:15 — Time Signed
2-11-2022 — Date Signed

Mother
If Signed by Surrogate, Relationship to Patient

OPTIONAL
[redacted]
Additional Adult Witness Signature

0810 — Time Signed
2/12/22 — Date Signed

TREATING PRACTITIONER USE ONLY

I have discussed with the patient the nature of the proposed care, treatment, services, medications, interventions or procedures; the potential benefits, risks or side effects, including potential problems related to recuperation; the likelihood of achieving care, treatment and service goals; the reasonable alternatives to the proposed care, treatment and service; the relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations on the confidentiality of information learned from or about the patient.

Signed: [redacted] Date: 2/11/22 Time: 3:16 pm

DOCUMENTATION OF EMERGENT/URGENT PROCEDURE

This procedure was performed emergently.

Signed: _____ Date: _____ Time: _____