CONSENT FOR PROCEDURE

By signing this form, I agree to the procedure(s) listed here:

- Esophagogastroduodenoscopy with biopsies
- 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 (hapatitis 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:

---

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: 2/11/2022 Time: 3:16pm

---

DOCUMENTATION OF EMERGENT/URGENT PROCEDURE

This procedure was performed emergently.

Signed: [Redacted] Date: 2/11/2022 Time: 3:16pm

---

CONSENT FOR PROCEDURE (Page 1 of 1) (SPANISH VERSION 64206)