



**THE GASTROENTEROLOGY CENTER OF VIRGINIA, PLLC
SURGICAL CONSENT FORM**

Patient Name		Date		
Proposed Procedure COLONOSCOPY WITH POSSIBLE BIOPSY				
Proposed Procedure				
Referring MD	Date of Birth	Age	Sex	Surgeon

**CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS AND RENDERING OF OTHER MEDICAL SERVICES, INCLUDING
CONSENT FOR TRANSFUSION (S)**

- The Endoscopy Center maintains personnel and facilities to assist your physician (s) and surgeon (s) in their performance of various endoscopic procedures. These procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedure: the expected benefits or effects of such procedures: and the available alternative methods of treatment and their risks and benefits. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed procedure any time prior to its performance.
- Your physician (s) and surgeon(s) have recommended the procedures set forth above. Upon your authorization and consent, the procedures set forth above, together with any different or further procedures, which, in the opinion of the supervising physician may be indicated due to an emergency, will be performed on you, the patient. The procedures will be performed by the physician named above (or in the event of an emergency causing his or her inability to complete the procedure, a qualified substitute physician), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff to whom the physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the Center or your physician or surgeon, but are independent contractors and , therefore, your agents, servants, or employees.
- The pathologist is hereby authorized to use his or her discretion in disposing of any member, organ or other tissue removed from your person during the operations or procedures set forth above.
- Your signature below constitutes your acknowledgment that (1) you have read and agree to the foregoing: (2) that the procedure set forth above has been adequately explained to you by the above named physician or surgeon: (3) that you authorize and consent to the performance of the operation or procedure: (4) that you authorize and consent to the administration of anesthesia for the said operative procedure; and (5) that you have read the Patient's Bill of Rights.
- ADVANCED DIRECTIVES- I understand that even though the physicians and staff of the Surgery Center respect my rights to participate in decisions regarding my health care, the policy of the Surgery Center is that all patients undergoing surgical procedures will be considered eligible for life-sustaining emergency treatments.
- I have made arrangements to have a responsible adult drive me home and care for me for the next 24 hours.
- I consent to the admittance of surgical assistants and or technicians to the Procedure Room and to the photographing and projection of the procedure(s) from the endoscopy scope, to be performed on a video monitor, including appropriate portions of my body for the treatment of my illness or physical condition. All pictures will remain exclusive property of the Endoscopy Center.

Date: _____

Signature:) _____

Time: _____

(Patient, Conservator, Guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____