Central Massachusetts AEC

105 Erdman Way
Leominster, MA. 01453
978-840-6767

1. I authorize the performance upon _____
(MYSELF OR NAME OF PATIENT)

of the following operation/procedure Colonoscopy_with biopsy and polyp removal_____

to be performed by or under the direction of **Dr. Feinberg**

2. I consent to the performance of operations and procedures in addition or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his/her associates or assistants may consider necessary or advisable in the course of the operation.

3. The nature and purpose of the operation/procedure, possible alternative methods of treatment, the risks involved, and the possible consequences and the possibility of complications have been explained to me by **Dr. Feinberg**.

4. 1 acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

5. I consent to the disposal by hospital authorities of any tissue or body parts which may be removed, with the exception of major body parts.

6. I consent to the administration of the appropriate conscious sedation agents that may be necessary for the performance of the procedures indicated above.

The above procedure was explained to the patient along with its possible benefits, risks, and complications on

_____(date)SIGNED_____
(patient or person authorized to consent)

The patient (or representative) signed this document in my presence of his/her own free will.

DATE:_____ WITNESS:_____
(if physician is not present at signing)

_____M.D. DATE:_____

INFORMED CONSENT FOR SURGERY

LW _____
REF _____
AUTH _____
MOR _____
ASC _____

COLONOSCOPY WITH BIOPSY

COLONOSCOPY IS THE EXAMINATION OF THE LINING OF THE LARGE INTESTINE (COLON) WITH A FLEXIBLE RUBBER TUBE WITH A LIGHT ON THE END OF IT. OFTEN YOUR PHYSICIAN WILL GIVE YOU MEDICATION TO MAKE YOU DROWSY. THEN THE TUBE IS INSERTED INTO YOUR RECTUM ALLOWING YOUR PHYSICIAN TO ADVANCE THE TUBE ALONG YOUR LARGE INTESTINE. IF ANY ABNORMALITY IS SEEN A SMALL PORTION OF TISSUE (BIOPSY) MAY BE REMOVED FOR MICROSCOPIC STUDY. DURING THE COURSE OF THIS EXAMINATION, A POLYP MAY BE FOUND AND REQUIRE THE USE OF A WIRE LOOP AND ELECTRIC CURRENT (CAUTERY) TO REMOVE THE POLYP.

A BIOPSY IS THE REMOVAL AND EXAMINATION OF TISSUE FROM THE G.I. TRACT TO ESTABLISH A PRECISE DIAGNOSIS. THIS PROCEDURE IS PERFORMED WITH A SMALL CUTTING INSTRUMENT INSERTED THROUGH THE COLONOSCOPE. IT IS USUALLY COMPLETELY PAINLESS, BUT MAY PRODUCE SOME BLEEDING. RARELY, PERFORATION MAY OCCUR.

THE FOLLOWING RARE COMPLICATIONS MAY OCCUR AND INCLUDE:

1) UNEXPECTED ALLERGIC REACTION TO THE MEDICATION.
2) PERFORATION WHICH MAY REQUIRE SURGERY.
3) BLEEDING WHICH MAY REQUIRE TRANSFUSIONS.

_____

Your name

Central Massachusetts AEC

105 Erdman Way
Leominster, MA. 01453
978-840-6767

1. I authorize the performance upon _____
(MYSELF OR NAME OF PATIENT)

of the following operation/procedure UPPER ENDOSCOPY with biopsy

to be performed by or under the direction of **Dr. Feinberg.**

2. I consent to the performance of operations and procedures in addition or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the abovenamed doctor or his/her associates or assistants may consider necessary or advisable in the course of the operation.

3. The nature and purpose of the operation/procedure, possible alternative methods of treatment, the risks involved, and the possible consequences and the possibility of complications have been explained to me by **Dr. Feinberg.**

4. 1 acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

5. I consent to the disposal by hospital authorities of any tissue or body parts which may be removed, with the exception of major body parts.

6. I consent to the administration of the appropriate conscious sedation agents that may be necessary for the performance of the procedures indicated above.

The above procedure was explained to the patient along with its possible benefits, risks, and complications on

_____(date) SIGNED_____
(patient or person authorized to consent)

The patient (or representative) signed this document in my presence of his/her own free will.

DATE:_____ WITNESS:_____
(if physician is not present at signing)

_____M.D. DATE:_____
Dr Elliot Feinberg, M.D.

INFORMED CONSENT FOR SURGERY

LW _____
REF _____
AUTH _____
MOR _____
ASC _____

UPPER ENDOSCOPY WITH BIOPSY

This test permits evaluation of your stomach, esophagus, and small intestine by means of a flexible tube. Medication may be given to make your throat numb and in most cases you will be given a sedative in the vein to help you relax. The doctor will then place the instrument on your tongue and ask you to swallow. As you swallow, the tube passes through the mouth into the esophagus. The test takes between two and thirty minutes.

An endoscopic biopsy is the removal and examination of tissue from the G.I. tract to establish a precise diagnosis. This procedure is performed with a small cutting instrument inserted through the endoscope. It is usually completely painless, but may produce some bleeding. Rarely, perforation may occur.

Possible rare complications can include: 1) Unexpected allergic reaction to the medications used. 2) Inhalation of stomach juices into the lungs. This could lead to pneumonia. 3) Perforation which may require surgery. E) Bleeding which may require transfusions. 5) Over sedation from the medications used for sedation. 6) Infection. 7) Bleeding that could require transfusion.